# North Carolina Medicaid Special Bulletin



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# Attention: All Health Check Providers

Effective July 1, 2003



Health Check Billing Guide 2003

## **COMMITMENT TO QUALITY**

EDS and DMA share a common goal with the provider community to ensure quality health care is provided to all North Carolina Medicaid recipients in the most efficient and economical manner.



Quality is the process of delivering products and services that meet our customers' requirements and exceed their expectations to generate customer satisfaction and success.

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Effective with claims processed on or after July 1, 2003, several changes have been made to the Health Check Program. These changes are outlined in this special bulletin. Please replace the July 2002 Special Bulletin IV, *Health Check Billing Guide 2002* with this special bulletin. For your convenience, shading indicates new information

DMA and EDS continue the effort to comply with HIPAA requirements. Effective August 1, 2003, the N.C. Medicaid program will begin accepting the ASC X12N 837 Health Care Claim Professional transaction. The current N.C. Medicaid electronic formats will continue to be accepted until October 16, 2003.

#### HEALTH CHECK SCREENING COMPONENTS

The Health Check Program is a preventive care program for Medicaid-eligible children ages birth through 20. A Health Check screening is the only well child preventive visit reimbursable by Medicaid. All Health Check components are required and are to be documented in the patient's medical record. Each screening component is vital for measuring a child's physical, mental, and developmental growth. Recipients are encouraged to receive their comprehensive health checkups and immunizations on a regular schedule. A complete Health Check screening consists of the following age-appropriate components, which must be performed and documented at each visit unless otherwise noted.

- Comprehensive unclothed physical examination
- Comprehensive health history
- Nutritional assessment
- Anticipatory guidance and health education
- Measurements, blood pressure, and vital signs

Blood pressure is required to become a part of the exam at age 3.

#### • Developmental screening including mental, emotional, and behavioral

Perform age-appropriate evaluation at **each** screening. In addition, three written developmental assessments should be performed: the first by 12 months, the second by 24 months, and the third by 60 months of age.

#### Immunizations

Federal regulations state that immunizations are to be provided at the time of screening if they are needed.

#### Vision and hearing assessments

Health Check follows the Recommendations for Preventive Pediatric Health Care from the American Academy of Pediatrics for hearing and vision assessments. The Recommendations for all screening components may be accessed at <a href="http://www.aap.org/policy/re9939.html">http://www.aap.org/policy/re9939.html</a>.

In accordance with the periodicity schedule and the Recommendations for Preventive Pediatric Health Care, **objective** vision assessment (i.e., Snellen chart) is required at ages 3 years, 4 years, 5 years, 6 years, 9 years, 12 years, 15 years, and 18 years.

In accordance with the periodicity schedule and the Recommendations for Preventive Pediatric Health Care, objective hearing assessments **using electronic equipment** (i.e., audiometer) must be performed at birth, 4 years, 5 years, 6 years, 9 years, 12 years, 15 years, and 18 years.

If the required vision and/or hearing screenings cannot be performed during a periodic visit due to blindness or deafness and the claim is denied, the claim may be resubmitted through the adjustment process with supporting medical record documentation attached.

#### Dental screenings

A dental referral is required for every child beginning at 3 years of age. An oral screening performed during a physical examination is not a substitute for examination through direct referral to a dentist. The initial dental referral must be provided regardless of the periodicity schedule unless it is known that the child is already receiving dental care. Thereafter, dental referrals should, at a minimum, conform to the dental service periodicity schedule, which is currently one routine dental examination every six months. When any screening indicates a need for dental services at an earlier age (i.e., baby bottle caries), referrals must be made for needed dental services and documented in the patient's record. The periodicity schedule for dental examinations is not governed by the schedule for regular health screenings.

**Note:** Dental varnishing is not a requirement of the Health Check screening exam. Providers may bill for dental varnishing and receive reimbursement in addition to the Health Check screening. Providers are to utilize the codes and billing guidelines indicated in the August 2002 general Medicaid bulletin. Bulletins are available on the Division of Medical Assistance (DMA) website at <a href="http://www.dhhs.state.nc.us/dma">http://www.dhhs.state.nc.us/dma</a>.

#### Laboratory procedures

Includes hemoglobin or hematocrit, urinalysis, sickle cell, tuberculin skin test, and lead screening.

Note: When these laboratory tests are processed in the provider's office, Medicaid will not reimburse separately for these procedures. Payment for these procedures is included in the reimbursement for a Health Check screening.

#### Hemoglobin or hematocrit

Hemoglobin or hematocrit must be measured once during infancy (between the ages of 9 and 12 months) for all children and once during adolescence for menstruating adolescent females. An annual hemoglobin or hematocrit screening for adolescent females (ages 11 to 21 years) must be performed if any of the following risk factors are present: moderate to heavy menses, chronic weight loss, nutritional deficit or athletic activity.

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) has specific guidelines for hematocrit/hemoglobin testing. Sharing the test results between the WIC Program and the primary care provider (PCP) is encouraged with appropriate release of information. For more information on guidelines and time frames, call the local WIC office.

#### Urinalysis

Urinalysis must be performed during the 5-year-old periodic screening as well as during periodic screenings for all sexually active males and females.

#### Sickle cell testing

North Carolina hospitals are required to screen all newborns for sickle cell prior to discharge. If a child has been properly tested, this test need not be repeated. **Results must be documented in the child's medical record.** If the test results of the newborn sickle cell screening are not readily available, contact the hospital of birth. An infant not tested at birth should receive a sickle cell test prior to 3 months of age.

#### Laboratory procedures, continued

#### **Tuberculin testing**

Reviewing perinatal histories, family and personal medical histories, significant events in life, and other components of the social history will identify children/adolescents for whom TB screening is indicated. If none of the screening criteria below are present, there is no recommendation for routine TB screening.

The North Carolina TB Control Branch is responsible for oversight of testing of household and other close contacts of active cases of pulmonary and laryngeal tuberculosis. Questions related to policy interpretation or other questions related to TB skin testing should be directed to the local health departments.

Tuberculin testing should be performed as clinically indicated for children/adolescents at increased risk of exposure to tuberculosis, via Purified Protein Derivative (PPD) intradermal injection/Mantoux method – not Tine Test.

Criteria for screening children/adolescents for TB (per the NC TB Control Branch) are:

- 1. Children/adolescents reasonably suspected of having tuberculosis disease based on clinical symptoms.
- 2. Do a **baseline screen** when these children/adolescents present for care.
  - a. Foreign-born individuals arriving within the last five years from Asia, Africa, Caribbean, Latin America, Mexico, South America, Pacific Islands, the Middle East or Eastern Europe. Low prevalence countries for tuberculosis disease are the USA, Canada, Japan, Australia, New Zealand, and countries in Western Europe.
  - b. Children/adolescents who are migrants, seasonal farm workers, or are homeless.
  - c. Children/adolescents who are HIV-infected.
  - d. Children/adolescents who inject illicit drugs or use crack cocaine.

Subsequent TB skin testing is not necessary unless there is a continuing risk of exposure to persons with tuberculosis disease.

#### In addition to the TB Control Branch criteria:

A TB screening performed as a part of a Health Check screening cannot be billed separately.

#### Laboratory procedures, continued

#### Lead screening

Federal regulations state that all Medicaid-enrolled children are required to have a blood lead test at 12 and 24 months of age. Children between 36 and 72 months of age must be tested if they have not been previously tested. Providers should perform a lead screening when it is clinically indicated.

Medical follow-up begins with a blood lead level greater than or equal to 10 ug/dL. Capillary blood level samples are adequate for the initial screening test. Venous blood level samples should be collected for confirmation of all elevated blood lead results.

| Blood Lead<br>Concentration | Recommended Response   |
|-----------------------------|--|
| <10 ug/dL                   | Rescreen at 24 months of age   |
| 10 to 19 ug/dL              | Confirmation (venous) testing should be conducted within three months. If confirmed, repeat testing should be conducted every 2 to 4 months until the level is shown to be $<10$ ug/dL on three consecutive tests (venous or fingerstick). The family should receive lead education and nutrition counseling. A detailed environmental history should be taken to identify any obvious sources of exposure. If the blood lead level is confirmed at $\ge 10$ ug/dL, environmental investigation will be offered. |
| 20 to 44 ug/dL              | Confirmation (venous) testing should be conducted within 1 week. If confirmed, the child should be referred for medical evaluation and should continue to be retested every 2 months until the blood lead level is shown to be <10 ug/dL on three consecutive tests (venous or fingerstick). Environmental investigations are required and remediation for identified lead hazards shall occur for all children less than 6 years old with confirmed blood lead levels >20 ug/dL.                                |
| ≥45 ug/dL                   | The child should receive a venous lead test for confirmation as soon as possible. If confirmed, the child must receive urgent medical and environmental follow-up. Chelation therapy should be administered to children with blood lead levels in this range. Symptomatic lead poisoning or a venous lead level >70 ug/dL is a medical emergency requiring inpatient chelation therapy.  |

#### State Laboratory of Public Health for Blood Lead Screening

The State Laboratory Services of Public Health will analyze blood lead specimens for all children less than 6 years of age at no charge. Providers requiring results of specimens from children outside this age group need to contact the State Laboratory of Public Health at 919-733-3937.

#### HEALTH CHECK SCREENING SCHEDULES

#### **Periodic Screenings**

The preventive medicine CPT codes 99381 through 99385 with the modifier EP, and 99391 through 99395 with the modifier EP are used to bill a periodic screening. (Refer to Health Check Billing Requirements on page 9.)

The schedule below outlines the recommended frequency of Health Check screenings dependent upon the age of the child. This schedule is based on recommendations for preventive pediatric health care.

**Note:** If an illness is detected during a Health Check screening, the provider may continue with the screening or bill a sick visit and reschedule the screening for a later date.

#### **Periodicity Schedule**

| Within the first month | 12 months | 5 years                       |
|------------------------|-----------|-------------------------------|
| 2 months               | 18 months | 6 through 20 years            |
| 4 months               | 2 years   | One screening every three     |
| 6 months               | 3 years   | years for children 6 years of |
| 9 or 15 months         | 4 years   | age and older.                |

#### **Interperiodic Screenings**

The preventive medicine CPT codes 99381 through 99385 with the modifier EP, and 99391 through 99395 with the modifier EP are used to bill an interperiodic screening. (Refer to Health Check Billing Requirements on page 9.)

In addition to the periodicity schedule, interperiodic screenings are allowed in the following circumstances:

- When a child requires either a kindergarten or sports physical **outside** the regular schedule.
- When a child's physical, mental or developmental illnesses or conditions have already been diagnosed and there are indications that the illness or condition may require closer monitoring.
- When the screening provider has determined there are medical indications that make it necessary to schedule additional screenings in order to determine whether a child has a physical or mental illness or a condition that may require further assessment, diagnosis or treatment.
- Upon referral by a health, developmental or educational professional based on their determination of medical necessity. Examples of referral sources may include Head Start, Agricultural Extension Services, Early Intervention Programs or Special Education Programs.

In each of these circumstances, the screening provider must specify and document in the child's medical record the reason necessitating the interperiodic screening.

Hearing and vision assessments are not required for an interperiodic screening. All other Health Check components must be performed during an interperiodic Health Check screening.

#### **IMMUNIZATIONS**

#### Immunization Administration CPT Codes 90471 and 90472; with the EP Modifier

Medicaid reimburses providers for the administration of immunizations to Medicaid-enrolled children, birth through 20 years of age, using the following guidelines.

#### **Private Sector Providers**

An immunization administration fee may be billed if it is the only service provided that day or if any immunizations are provided in addition to a Health Check screening or an office visit.

- Administration of one immunization is billed with the administration CPT code 90471 (one unit) with the **EP** modifier and is reimbursed at \$13.71.
- Additional immunizations are billed with the administration CPT code 90472 with the **EP** modifier and are reimbursed at \$13.71.

The maximum reimbursement for two or more immunizations will remain at \$27.42 when using both CPT codes 90471 and 90472. The **EP** modifier must be listed next to each immunization administration CPT code entered in block 24D of the CMS-1500 claim form. Immunization procedure codes must be reported even if the immunization administration fee is not being billed. For instructions on billing an immunization administration fee, refer to the chart on page 7.

#### Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) Providers

An immunization administration fee may be billed if it is the only service provided that day or if any immunizations are provided in addition to a Health Check screening. Health Check screenings and the immunization administration fees are billed under the Medicaid provider number with the "C" suffix.

- Administration of one immunization is billed with the CPT code 90471 (one unit) with the EP modifier and is reimbursed at \$13.71.
- Additional immunizations are billed with the administration CPTcode 90472 with the **EP** modifier and are reimbursed at \$13.71.

An immunization administration fee cannot be billed in conjunction with a core visit. Report the immunization given during the core visit without billing the administration fee. For instructions on billing an immunization administration fee, refer to the chart on page 7.

#### **Local Health Department Providers**

An immunization administration fee may **not** be billed if immunization(s) is provided in addition to a Health Check screening. The immunization administration CPT codes 90471 with the **EP** modifier may be billed if immunizations are the only services provided that day or if any immunizations are provided in conjunction with an **office visit**.

• Administration of one or more immunizations is billed with the CPT code 90471 (one unit) with the **EP** modifier and is reimbursed at \$20.00.

The immunization administration code is reimbursed at \$20.00 regardless of the number of immunizations given. Immunization procedure codes must be reported even if the immunization administration fee is not being billed. For instructions on how to bill an immunization administration fee, refer to the chart on page 7.

## Immunizations, continued

## **Billing Guidelines for Immunizations**

| Provider Type                           | Health Check<br>Screening with<br>Immunization(s)              | Immunization(s) Only  | Office Visit with Immunization(s)                               | Core Visit with<br>Immunization(s)                                     |
|---|--|---|---|--|
| Private Sector<br>Providers             | For one immunization, bill 90471 with the EP modifier.         | For one immunization, bill 90471 with the EP modifier.          | For one immunization, bill 90471 with the EP modifier.          | N/A  |
|   | For additional immunizations, bill 90472 with the EP modifier. | For additional immunizations, bill 90472 with the EP modifier.  | For additional immunizations, bill 90472 with the EP modifier.  |  |
|   | Immunization diagnosis code <b>not</b> required.               | One immunization diagnosis code is required.                    | Immunization diagnosis code <b>not</b> required.                |  |
|   | Immunization procedure code(s) are required.                   | Immunization procedure code(s) are required.                    | Immunization procedure code(s) are required.                    |  |
| FQHC/RHC                                | For one immunization, bill 90471 with the EP modifier.         | For one immunization, bill 90471 with the EP modifier.          | N/A   | Cannot bill 90471 or 90472.  Immunization diagnosis code is <b>not</b> |
|   | For additional immunizations, bill 90472 with the EP modifier. | For additional immunizations, bill 90472 with the EP modifier.  |   | required.  Immunization procedure code(s) are required.                |
|   | Immunization diagnosis code <b>not</b> required.               | One immunization diagnosis code is required.                    |   | required.  |
|   | Immunization procedure code(s) are required.                   | Immunization procedure code(s) are required.                    |   |  |
| Local Health<br>Department<br>Providers | Cannot bill 90471.<br>Must report<br>immunizations.            | For one or more immunizations, bill 90471 with the EP modifier. | For one or more immunizations, bill 90471 with the EP modifier. | N/A  |
|   | Immunization diagnosis code <b>not</b> required.               | One immunization diagnosis code is required.                    | Immunization diagnosis code is <b>not</b> required.             |  |
|   | Immunization procedure code(s) are required.                   | Immunization procedure code(s) are required.                    | Immunization procedure code(s) are required.                    |  |

Immunization procedure code(s) must be listed in block 24D of the CMS-1500 claim form for all immunizations administered.

#### Universal Childhood Vaccine Distribution Program/Vaccines for Children Program

The Universal Childhood Vaccine Distribution Program (UCVDP)/Vaccines for Children (VFC) Program provides at no charge all required (and some recommended) vaccines to North Carolina children birth through 18 years of age according to the recommendations of the Advisory Committee of Immunization Practices (ACIP) of the Centers for Disease Control (CDC). Due to the availability of these vaccines, Medicaid does not reimburse for UCVDP/ VFC vaccines for children ages birth through 18. An exception to this is noted below the table.

For Medicaid-eligible recipients ages 19 through 20 who are not age-eligible for the VFC program vaccines, Medicaid will reimburse providers for Medicaid-covered vaccines.

#### The following is a list of UCVDP/VFC vaccines:

| Codes | Vaccines   | Diagnosis Codes |
|-------|--|-----------------|
| 90645 | Hib Titer- 4 dose HBOC   | V03.8 or V05.8  |
| 90647 | Hib-3 dose PRP-OMP (Pedvax)  | V03.8 or V05.8  |
| 90648 | Hib-4 dose PRT-T (ActHib)  | V03.8 or V05.8  |
| 90657 | Influenza (6 to 35 months of age) High-Risk Only   | V04.8           |
| 90658 | Influenza (3 years of age and above) High-Risk Only  | V04.8           |
| 90669 | Pneumococcal - PCV7 (2 through 59 months of age)   | V03.82 or V05.8 |
| 90700 | DTaP   | V06.8           |
| 90702 | DT   | V06.8           |
| 90707 | MMR  | V06.4           |
| 90713 | IPV  | V04.0           |
| 90716 | Varicella  | V05.4           |
| 90718 | Td   | V06.5           |
| 90732 | Pneumococcal - PPV23 High-Risk Only  | V03.82 or V05.8 |
| 90744 | Hepatitis B Vaccine – Pediatric/Adolescent   | V05.8           |
|       | If the first dose of hepatitis B vaccine is administered prior to the 19 <sup>th</sup> birthday, UCVDP vaccine can be used to complete the series prior to the 20 <sup>th</sup> birthday. Medicaid will reimburse for hepatitis B vaccine for <b>high-risk</b> individuals 19 years of age and older |                 |

North Carolina Medicaid providers who are not enrolled in the UCVDP or who have questions concerning the program should call the N.C. Division of Public Health's Immunization Branch at 1-800-344-0569.

Out-of-state providers (within the 40-mile radius of North Carolina) may obtain VFC vaccines by calling their state VFC program. VFC program telephone numbers for border states are listed below:

- **Georgia** 1-404-657-5013
- South Carolina 1-800-277-4687
- Tennessee 1-615-532-8513
- Virginia 1-804-786-6246

#### HEALTH CHECK BILLING REQUIREMENTS

Instructions for billing a Health Check screening on the CMS-1500 claim form are the same as when billing for other medical services except for these six critical requirements. The six billing **requirements** specific to the Health Check Program are as follows:

#### Requirement 1: Identify and Record Diagnosis Code(s)

Place diagnosis code(s) in the correct order in block 21. Medical diagnoses should <u>always</u> be listed before immunization diagnoses. Immunization diagnoses are required when billing immunization(s) only.

#### Periodic Health Check Screening – Use V20.2 as the Primary Diagnosis

Medical diagnoses are listed after the primary diagnosis (V20.2). Medical diagnoses should <u>always</u> be listed before immunization diagnoses. Immunization diagnoses are required when billing immunization(s) only.

#### Interperiodic Health Check Screening – Use V70.3 as the Primary Diagnosis

Medical diagnoses are listed after the primary diagnosis (V70.3). Medical diagnoses should <u>always</u> be listed before immunization diagnoses. Immunization diagnoses are required when billing immunization(s) only.

#### **Requirement 2: Identify and Record Preventive Medicine Code(s)**

The preventive medicine CPT codes with the EP modifier for Health Check screenings should be billed as outlined below. In addition to billing the preventive medicine codes, vision and hearing CPT codes must be listed based on the ages outlined in the Health Check Screening Components indicated on page 1.

- A Health Check screening is the only well child visit reimbursable by Medicaid and must have V20.2 or V70.3 as the primary diagnosis code.
- Vision and hearing CPT codes must be listed in addition to the preventive medicine CPT codes for a periodic Health Check screening. No additional reimbursement is allowed for these codes.

Use the correct Health Check screening preventive medicine codes with the EP modifier in block 24D of the CMS-1500 claim form:

| Screenings         | Preventive CPT Codes and Modifier                   | <b>Diagnoses Codes</b>  |
|--------------------|---|-------------------------|
| Periodic Screening | CPT codes 99381-99385; 99391-99395                  | V20.2 Primary Diagnosis |
|                    | EP Modifier is required in block 24D                |                         |
|                    |   |                         |
|                    | Vision CPT code 99172 or 99173; beginning at age 3  |                         |
|                    | EP Modifier is required in block 24D                |                         |
|                    | Hearing CPT code 92551 or 92552; beginning at age 4 |                         |
|                    | EP Modifier is required in block 24D                |                         |
| Interperiodic      | CPT codes 99381-99385; 99391-99395                  | V70.3 Primary Diagnosis |
| Screening          | EP Modifier is required in block 24D                |                         |

#### Health Check Billing Requirements, continued

#### **Requirement 3: Health Check Modifier – EP**

The Health Check screening CPT codes for periodic and interperiodic screenings must have the **EP** modifier listed in block 24D of the CMS-1500 claim form. The vision and hearing CPT codes must have the **EP** modifier listed in block 24D of the CMS-1500 claim form. EP is a required modifier for all Health Check claims.

#### **Requirement 4: Record the Referral Code Indicator – R**

A referral code indicator is used only when a follow-up visit is necessary for a diagnosis found during a Health Check screening. The indicator "R" should be listed in block 24H of the CMS-1500 claim form when this situation occurs. Refer to pages 17, 18, 28, and 29 for sample claims.

#### **Requirement 5: Next Screening Date**

Providers may enter the next screening date (NSD) or have the NSD systematically entered according to the predetermined Medicaid periodicity schedule. Below is an explanation of options for the NSD in block 15 of the CMS-1500 claim form.

#### **Systematically Entered Next Screening Date**

Providers have the following choices for block 15 of the CMS-1500 claim form with a Health Check screening. All of these choices will result in an automatically entered NSD.

- Leave block 15 blank.
- Place all zeros in block 15 (00/00/0000).
- Place all ones in block 15 (11/11/1111).

Claims with systematically entered NSDs will be tracked per the Medicaid periodicity schedule.

#### **Provider-Entered Next Screening Date**

Providers have the option of entering the NSD in block 15. If this date is within the periodicity schedule, the system will keep this date. In the event the NSD is out of range with the periodicity schedule, the system will override the provider's NSD and the appropriate NSD (based upon the periodicity schedule) will be automatically entered during claims processing.

# Requirement 6: Identify and Record Immunization Administration CPT Code(s) and the EP Modifier

Refer to the chart on page 7 for guidelines on when to bill the immunization administration CPT codes and the EP modifier.

When billing one immunization, use the administration CPT code 90471 (one unit) with the EP modifier listed in block 24D.

When additional immunizations are provided, use the administration CPT code 90472 with the EP modifier listed in block 24D.

Refer to pages 18, 19, 20/21, 22/23, 24 through 27, 29, and 32 for sample claims.

**Note:** If the **EP** modifier is not listed in block 24D, the reimbursement rate for the CPT codes 90471 and 90472 is \$0.00.

#### TIPS FOR BILLING

#### All Health Check Providers

- Two screenings on different dates of service cannot be billed on the same claim form.
- If the required vision and/or hearing screenings cannot be performed during a periodic visit due to a condition such as blindness or deafness and the claim is denied, the claim may be resubmitted through the adjustment process with supporting medical record documentation attached.
- When billing immunization administration CPT codes, the EP modifier must be entered in block 24D to receive the reimbursement rate of \$13.71 for 90471 (health departments receive \$20.00) and \$13.71 for 90472 (no additional reimbursement for health departments). If the EP modifier is not entered in block 24D, the reimbursement will be \$0.00 per unit. The reimbursement for these codes is \$3.41 per unit for non-Health Check related services. Local health departments should follow directions on pages 6 and 7 when billing these codes.
- Third party insurance must be pursued and reported in block 29 of the CMS-1500 claim form when preventive services (well child screenings) are covered. If third party insurance does not cover preventive services, clearly document in the medical record and submit a claim to Medicaid.
- When checking claim status using the Automated Voice Response (AVR) system (1-800-723-4337), AVR requires providers to enter the total amount billed. Due to each Health Check claim being divided into two separate claims for tracking purposes, the total amount billed must also be split between the amount billed for the screening and the amount billed for immunizations and any other service billed on the same date of service. Thus, it will be necessary to check claim status for two separate claims.

#### **Private Sector Health Check Providers Only**

- A Health Check screening and an office visit with different dates of service cannot be billed on the same claim form.
- A Health Check screening and an office visit cannot be paid initially on the same date of service.
  One claim will pay and the other will deny. For the denied claim to be reconsidered, it must be submitted as an adjustment with medical justification and a copy of the Remittance and Status Report (RA) denial attached.
- Immunization administration CPT code 90471 with the EP modifier and 90472 with the EP modifier can be billed with a Health Check screening, office visit or if it is the only service provided that day. When billing in conjunction with a screening CPT code or an office visit code, an immunization diagnosis is not required in block 21 of the claim form. When billing the administration code for immunizations (90471 with the EP modifier and 90472 with the EP modifier) as the only service for that day, providers are required to use an immunization diagnosis in block 21 of the claim form.

  Always list immunization CPT procedure codes when billing 90471 with the EP modifier and 90472 with the EP modifier. Refer to the chart on page 7 and the sample claim forms beginning on pages 15 through 27.

#### Tips for Billing, continued

#### Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Providers Only

- FQHCs and RHCs must bill Health Check services using their Medicaid provider number with the "C" suffix.
- A Health Check screening and a core visit cannot be paid initially on the same date of service. One claim will pay and the other will deny. For the denied claim to be reconsidered, it must be submitted as an adjustment with medical justification and a copy of the RA denial attached.
- Immunization administration CPT code 90471 with the EP modifier and 90472 with the EP modifier can be billed if it is provided in addition to a Health Check screening CPT code or if it is the only service provided that day. When billing in conjunction with a screening code, an immunization diagnosis is not required in block 21 of the claim form. When billing the administration code for immunizations (90471 with the EP modifier and 90472 with the EP modifier) as the only service for that day, an immunization diagnosis code is required to be entered in block 21 of the claim form. The administration code for immunizations cannot be billed in conjunction with a core visit. For reporting purposes, list immunization procedure codes in the appropriate block on the claim form. Always list immunization procedure codes when billing 90471 with the EP modifier and 90742 with the EP modifier. Refer to the chart on page 7 and the sample claim forms on pages 28 through 33.

#### HEALTH CHECK COORDINATORS

Health Check Coordinators (HCCs) are available to assist both **parents** and **providers** in assuring that Medicaid-eligible children have access to Health Check services. The roles of the HCCs include, but are not limited to the following:

- using the Health Check Automated Information and Notification System (AINS) for identifying and following Medicaid-eligible children, birth through 20 years of age, with regard to services received through the health care system
- assisting families to use the health care services in a consistent and responsible manner
- assisting with scheduling appointments or securing transportation
- acting as a local information, referral, and resource person for families
- providing advocacy services in addressing social, educational or health needs of the recipient
- initiating follow-up as requested by providers when families need special assistance or fail to bring children in for health screenings
- promoting Health Check and health prevention with other public and private organizations

Physicians and other PCPs and their office staff are encouraged to establish a close working relationship with HCCs. Ongoing communication significantly enhances recipient participation in Health Check and help make preventive care services more timely and effective.

#### HCCs are currently located in 78 North Carolina counties and Qualla Boundary.

HCCs are housed in local health departments, community and rural health centers, and other community agencies. A list of counties with HCCs is available on the DMA website at <a href="http://www.dhhs.state.nc.us/dma">http://www.dhhs.state.nc.us/dma</a>.

#### HEALTH CHECK CLAIM FORM SAMPLES

There are 17 CMS-1500 claim form samples, including two split claims (pages 20/21 and 22/23) and six examples of HSIS screens on the following pages.

**Note:** A copy of the back of the CMS-1500 claim form precedes the first sample. The back of the CMS claim form includes important information regarding Medicaid payments. The section on Medicaid Payments (Provider Certification) specifies that the provider of Medicaid services agrees to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, copayment or similar cost-sharing charges.

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties

#### REFERS TO GOVERNMENT PROGRAMS ONLY

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-faulti, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary at the size shas that the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS republished. regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32)

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411, 24(a) and 424.5(a) (6), and 44 USC 3101,41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," <u>Federal Register</u> Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S). To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S). Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary: however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P. L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

| ## HEALTH INSURANCE CLAIM FORM ## NEDCARD CHAMPUS CHAM | PLEASE<br>DO NOT<br>STAPLE<br>IN THIS                               |   |                                |            |                       |                          |  | °Per                                     | vate Provi<br>iodic Scre               | eni         | ng              |             |             |                   |           |
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| Is SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (Locally that the statements on the reverse apply to this bill and are made a part thereof.)  Signature on File SIGNATURE OF PHYSICIAN OR SUPPLIER SHLING NAME, ADDRESS, ZIP CODE RENDERED (If other than home or office)  132 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)  134 PHYSICIANS, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE RENDERED (If other than home or office)  111 Provider St. Provider Town, NC 12345  PINF 00000000  112 GRP# 10000000   |   | :   |                                |            |                       | 1                        |  |  |  |             |                 |             |             |                   |           |
| Is SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (Locally that the statements on the reverse apply to this bill and are made a part thereof)  Signature on File Date 11/16/03  VES NO S 80 33 S S 8033  32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)  Signature on File Date 11/16/03  VES NO S 80 33 S S 8033  33. PHYSICIANS, SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE RENDERED (If other than home or office)  Dr. Jane Provider 111 Provider St.  Provider Town, NC 12345   |   |   |                                | Ì          |                       |                          |  |  |  |             |                 |             |             |                   |           |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (1 confir than home or office)  32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)  33. PHYSICIANS. SUPPLIER'S BILLING NAME. ADDRESS. ZIP CODE RENDERED (if other than home or office)  34. NAME AND ADDRESS. ZIP CODE RENDERED (if other than home or office)  35. PHYSICIANS. SUPPLIER'S BILLING NAME. ADDRESS. ZIP CODE RENDERED (if other than home or office)  37. PHYSICIANS. SUPPLIER'S BILLING NAME. ADDRESS. ZIP CODE RENDERED (if other than home or office)  38. PHYSICIANS. SUPPLIER'S BILLING NAME. ADDRESS. ZIP CODE RENDERED (if other than home or office)  39. PHYSICIANS. SUPPLIER'S BILLING NAME. ADDRESS. ZIP CODE RENDERED (if other than home or office)  31. PHYSICIANS. SUPPLIER'S BILLING NAME. ADDRESS. ZIP CODE RENDERED (if other than home or office)  32. NAME AND ADDRESS. ZIP CODE RENDERED (if other than home or office)  33. PHYSICIANS. SUPPLIER'S BILLING NAME. ADDRESS. ZIP CODE RENDERED (if other than home or office)  34. PHYSICIANS. SUPPLIER'S BILLING NAME. ADDRESS. ZIP CODE RENDERED (if other than home or office)  35. NAME AND ADDRESS. ZIP CODE RENDERED (if other than home or office)  36. PHYSICIANS. SUPPLIER'S BILLING NAME. ADDRESS. ZIP CODE RENDERED (if other than home or office)  37. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)  37. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)  37. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)  38. PHYSICIANS. SUPPLIER'S BILLING NAME. ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)  37. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)  38. PHYSICIANS. SUPPLIER'S BILLING NAME. ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)  39. PHYSICIANS. SUPPLIER'S BILLING NAME. ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or | 25. FEDERAL TAX I.D. NUMBE  |   |                                | 26. F      | ATIENT'S ACC          | OUNT NO.                 |  |  |  |             |                 | INT PAI     | D           |                   |           |
| (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  Signature on File 11/16/03  PINE 0000000 GRP# 10000000   | INCLUDING DEGREES OR  | CREDENTIAL                                  |                                |            |                       |                          | TY WHERE                               |  | 33. PHYSICIAN'S, SUPI                  | PLIER'S     | BILLING         |             |             | RESS, ZIP CO      |           |
| Signature on File Provider Town, NC 12345  | (I certify that the statements of<br>apply to this bill and are mad | on the reverse<br>e a part thereo           | f.)                            | -          | •                     |                          | •                                      |  | Dr                                     |             |                 |             |             |                   |           |
|  | Signature on  | File  | 11/-                           | :<br> c /- |                       |                          |  |  | Pr                                     |             | der             | Tov         | m,          | NC 12             | 2345      |
|  |   | DATE  | 11/1                           | 6/(        |                       |                          |  |  |  |             | _               |             |             |                   |           |

| PLEASE<br>DO NOT                                      |   |                  |            |                    |  |   | Private Pr                                       |                 |           |           |           |                         |
|---|---|------------------|------------|--------------------|--|---|--|-----------------|-----------|-----------|-----------|-------------------------|
| STAPLE<br>IN THIS                                     |   |                  |            |                    |  |   | °Periodic S<br>°Vision onl                       |                 | eni       | ng        |           |                         |
| AREA  |   |                  |            |                    |  |   | VIBION ON  | -1              |           |           |           |                         |
| PICA  |   |                  |            |                    |  | HEALTH                                      | INSURANCE  | CLAI            | VI F      | ORN       | 1         | PICA                    |
| 1. MEDICARE (Medicare #)                              | MEDICAID (Medicaid #)                         | CHAMF<br>(Sponso |            | CHAMPY<br>(VA File | HEALTH PLAN  | FECA OT<br>BLK LUNG (SSN)                   | HER 1a. INSURED'S I.C                            | NUMBE 2222      |           |           | (FO       | PROGRAM IN I            |
| 2. PATIENT'S NAME                                     | (Last Name, First N                           |                  |            |                    | 3. PATIENT'S BIRTH DATE                                |   | 2222   |                 |           | ırsı Na   | me. Mia   | die Initiali            |
| Recipier  5. PATIENT'S ADDR                           |   |                  |            |                    | 6 PATIENT RELATIONSHI                                  |   | 7. INSURED'S ADD                                 | BESS (N         | Stre      | et)       |           |                         |
| 111 Reci  | pient St                                      | reet             |            | STATE              |  | Child Other                                 | _  |                 |           |           | 2,111,111 |                         |
| Recipien  |   |                  |            | NC                 |  | Other —                                     | CITY   |                 |           |           |           | STAT                    |
| ZIP CODE<br>12345                                     |   |                  |            | rea Code)<br>9999  | Employed Full-Time                                     | Part-Time                                   | ZIP CODE   |                 | T         | ELEPH     | ONE (IN   | CLUDE AREA CO           |
| 9. OTHER INSURED                                      | 'S NAME (Last Name                            | e. First Na      | me, Mid    | die Initial)       | 10. IS PATIENT'S CONDITI                               |   | 11. INSURED'S PO                                 | LICY GRO        | UP OF     | FECA      | NUMBE     | ER .                    |
| a. OTHER INSURED                                      | S POLICY OR GRO                               | UP NUME          | ER         |                    | a. EMPLOYMENT? (CURRE                                  | ENT OR PREVIOUS)                            | a. INSURED'S DAT                                 | E OF BIRT       | н         |           |           | SEX                     |
| b. OTHER INSURED                                      | S DATE OF BIRTH                               |                  | EX         |                    | YES b. AUTO ACCIDENT?                                  | NO PLACE (Sta                               |  |                 |           |           | м         | SEX F                   |
| MM DD YY  |   | м                | F          | _                  | YES  | NO  | b. EMPLOYER'S NA                                 | ME OR S         | CHOO      | L NAMI    |           |                         |
| c. EMPLOYER'S NAM                                     | ME OR SCHOOL NA                               | ME               |            |                    | c. OTHER ACCIDENT?                                     | - NO  | c. INSURANCE PLA                                 | N NAME (        | R PR      | OGRAN     | NAME      |                         |
| d. INSURANCE PLAN                                     | NAME OR PROGR                                 | AM NAME          |            |                    | 10d. RESERVED FOR LOCA                                 | -   | d. IS THERE ANOTH                                | IER HEAL        | тн ве     | NEFIT     | PLAN?     |                         |
| 10 DATIFUTE OR 11                                     | READ BACK O                                   | F FORM E         | BEFORE     | COMPLETING         | G & SIGNING THIS FORM. release of any medical or other |   |  | NO              | If ye     | s. return | to and    | complete item 9 a-      |
| to process this clai<br>below.                        | m. I also request pay                         | ment of go       | vernmen    | it benefits either | to myself or to the party who ac                       | cepts assignment                            | payment of medic<br>services describe            | a benefit       | to the    | unders    | igned pl  | hysician or supplier    |
| SIGNED  | NT: 4 ILLNESS (F                              | irst sympt       | om) OB     | 15                 | DATE   | D CAN AD II I ME                            | SIGNED   |                 |           |           |           |                         |
| MM DD YY  17. NAME OF REFERI                          | PREGNANO                                      | Cident) O        | R          |                    | F PATIENT HAS HAD SAME C<br>BIVE FIRST DATE MM : D     |   | FROM :   |                 |           |           |           |                         |
| 17. NAME OF HEFER                                     | HING PHYSICIAN O                              | HOTHER           | SOURC      | CE   17a.          | I.D. NUMBER OF REFERRING                               | 3 PHYSICIAN                                 | 18 HOSPITALIZATIO<br>MM DI<br>FROM               | N DATES<br>D YY | RELA      | TED TO    | CURR      | ENT SERVICES<br>DD   YY |
| 19. RESERVED FOR L                                    | OCAL USE                                      |                  |            | <u>.</u>           | · · · · · · · · · · · · · · · · · · ·                  |   | 20. OUTSIDE LAB?                                 |                 |           |           | ARGES     | '                       |
| 21. DIAGNOSIS OR NA                                   | ATURE OF ILLNESS                              | OR INJU          | RY. (RE    | LATE ITEMS 1       | 2.3 OR 4 TO ITEM 24E BY LIN                            | VE)   | YES<br>22. MEDICAID RESU                         |                 |           |           |           |                         |
| 1. <u>V2</u> 0 <u>.</u> 2                             |   |                  |            | 3.                 |  | +   | CODE   | - 1             | ORK       |           | REF. NO   | ).                      |
| 2. [  |   |                  |            | 4.                 | L  |   | 23. PRIOR AUTHORI                                | ZATION N        | UMBEI     | R         |           |                         |
| 24. A<br>DATE(S) OF<br>From                           | SERVICE <sub>To</sub>                         | Place            | Type<br>of | PROCEDURI          | D<br>ES. SERVICES, OR SUPPLIES                         | E<br>DIAGNOSIS                              | F  | G<br>DAYS       | H<br>PSDT | - 1       | J         | RESERVED FO             |
| 10 05 03  |   | Y Servic         | e Service  | CPT/HCPCS          | Unusual Circumstances) MODIFIER                        | CODE  | \$ CHARGES                                       | OR<br>UNITS     | Plan      | EMG       | сов       | LOCAL USE               |
|   |   |                  | -          | 99392              |  | <del> </del>                                | 80 33  | 1               |           |           |           |                         |
| 10; 05 , 03   | 10 05 0                                       | 3 11             | <u> </u>   | 9917               | B EP   |   | 0:00   | 1               |           |           |           |                         |
|   | 1 1   |                  |            |                    | 1  |   |  |                 |           |           |           |                         |
| : 1   | 1 1   |                  |            |                    | 1  |   |  | $\Box$          |           |           |           |                         |
|   |   | <b>†</b> –       |            |                    |  |   | <del>                                     </del> | +               | $\dashv$  |           |           |                         |
|   | 1   |                  |            |                    |  |   | -  |                 |           |           |           |                         |
| 5. FEDERAL TAX I.D. N                                 | UMBER SSA                                     | EIN              | 26 1       | PATIENT'S ACC      | COLINITARO   |   |  |                 |           |           |           |                         |
|   |   |                  | 20.1       | ATTENT S ACC       | COUNT NO. 27, ACCEP<br>(For gov<br>YES                 | T ASSIGNMENT?<br>1. claims, see back)<br>NO | s 80 3   | .               | AMOU      | NT PA     | D         | s 80                    |
| 31. SIGNATURE OF PHY<br>INCLUDING DEGREI              | ES OR CREDENTIA                               | LS               | 32. N      | AME AND ADI        | DRESS OF FACILITY WHERE other than home or office)     | SERVICES WERE                               | 33. PHYSICIAN'S, SUP                             | PLIER'S E       |           |           |           | IESS, ZIP CODE          |
| (I certify that the state<br>apply to this bill and a | ments on the reverse<br>ire made a part there | of.)             | 1          |                    | ,  |   | ) DI   | . Jo<br>1 Pr    |           |           |           | r<br>reet               |
| <u>Sig</u> nature                                     | on File                                       |                  |            |                    |  |   | Pro  | ovid            |           |           |           | NC 12345                |
|   | OII I I DETE                                  |                  | _          |                    |  |   | PIN# 0000000                                     |                 |           |           |           | 0000                    |
| (APPROVED BY AM                                       | IA COUNCE OF                                  | DICK:            |            |                    | LEASE PRINT OR TYP                                     |   | D OMB-0938-0008 FORM                             |                 |           |           |           |                         |

| DO NOT<br>STAPLE<br>IN THIS<br>AREA  |   |                   |   |  |                                 | °P6<br>°V:<br>°R6                      | rivate<br>eriodic<br>ision a<br>eferral | sci<br>nd t<br>Ind | reer<br>near<br>lica | ning<br>ing<br>tor    |                    |                  |   |
|--|---|-------------------|---|--|---------------------------------|--|---|--------------------|----------------------|-----------------------|--------------------|------------------|---|
| 1. MEDICARE MEDI   | AID CI  | HAMPUS            | CHAME   | VA GROU                                    | JP F                            | HEALTH IN                              | SURANO<br>R 1a. INSURED                 |                    |                      |                       |                    | (FOR F           | PICA PROGRAM IN ITEM 1)                     |
| (Medicare #) (Medi   | - but   | oonsor's          |   |  |                                 | (SSN) (ID)                             | 33                                      | 3333               | 3333                 | 3X                    |                    |                  |   |
| Recipient,   | _   | , Middle          | initial)  | 04 1                                       | В ВІЯТН DÀTE<br>7 1985 м        | SEX F X                                | 4. INSURED                              | S NAME             | (Last Na             | ime, First            | t Name,            | Middle           | Initial)                                    |
| 5. PATIENT'S ADDRESS (No. 111 Recipie  |   | oot               |   | 6. PATIENT F                               | Spouse Chi                      |  | 7. INSURED                              | ADDRE              | SS (No               | , Street)             |                    |                  |   |
| CITY   |   | eet               | STAT  | E 8. PATIENT S                             | - torrest                       |  | CITY                                    |                    |                      |                       |                    |                  | STATE                                       |
| Recipient T  |   | NE (Inci          | NC<br>ude Area Code)                                      | Single                                     | _ `                             | Other                                  | ZIP CODE                                |                    |                      | TELI                  | EPHON              | E (INC           | LUDE AREA CODE)                             |
| 12345<br>9. OTHER INSURED'S NAMI   |   |                   | 9-9999  | Employed 10 IS PATIE                       | Full-Time Student NT'S CONDITIO | Part-Time<br>Student                   | 11. INSURED                             | e police           | CV CBO               | UD OB 5               | (                  | )                |   |
|  |   |                   |   | _  |                                 |  |   |                    |                      |                       | ECAN               | JMBER            | <b>`</b>                                    |
| a. OTHER INSURED'S POLI  | Y OR GROUP I  | NUMBE             | 3   | a. EMPLOYM                                 | ENT? (CURREN                    | T OR PREVIOUS)                         | a. INSURED'S                            | DATE               | OF BIRT              | н                     | м                  |                  | SEX F                                       |
| b. OTHER INSURED'S DATE  |   | SE                |   | b. AUTO ACC                                |                                 | PLACE (State)                          | b. EMPLOYE                              | R'S NAM            | E OR SO              | CHOOL                 | NAME               | <u></u>          |   |
| c. EMPLOYER'S NAME OR S  | CHOOL NAME  |                   | F   | c. OTHER AC                                | YES CIDENT?                     | NO                                     | c. INSURANC                             | E PLAN             | NAME C               | OR PROC               | A MARE             | IAME             |   |
| d. INSURANCE PLAN NAME   | OR PROGRAM  | NAME              |   | 10d BESERV                                 | YES FOR LOCAL                   | NO                                     | d. IS THERE                             | MOTHE              | D UEA!               | TH DEN                | EEIT DI            | AND              |   |
|  |   |                   |   |  |                                 |  | YES                                     |                    | NO                   | If yes,               | return to          | and c            | omplete item 9 a-d.                         |
| <ol> <li>PATIENT'S OR AUTHOR<br/>to process this claim. I als<br/>below.</li> </ol>                            | ZED PERSON'S  | S SIGNA           | FORE COMPLET<br>TURE I authorize t<br>imment benefits eit | he release of any n                        | nedical or other in             | formation necessary apts assignment    | 13. INSURED payment of services d       | f medical          | benefits             | ZED PER<br>s to the u | RSON'S<br>Indersig | SIGNA<br>ned phy | TURE I authorize<br>ysician or supplier for |
| SIGNED   |   |                   |   | DAT  |                                 |  | SIGNED                                  |                    |                      |                       | ~                  |                  |   |
| 14. DATE OF CURRENT:   | ILLNESS (First<br>INJURY (Accid<br>PREGNANCY)                       | dent) OR<br>(LMP) |   | 5. IF PATIENT HA<br>GIVE FIRST DA          | S HAD SAME OF                   | R SIMILAR ILLNESS.                     | 16. DATES PA                            | TIENT U            | NABLE<br>  YY        | TO WOF                | RK IN C<br>TO      | мм               | NT OCCUPATION<br>DD   YY                    |
| 17. NAME OF REFERRING P  | YSICIAN OR C  | OTHER S           | SOURCE 1  | 7a. I.D. NUMBER                            | OF REFERRING                    | PHYSICIAN                              | 18. HOSPITAL<br>MM<br>FROM              | IZATION<br>DD      | DATES                | RELATI                | ED TO              | MM               | NT SERVICES<br>DD   YY                      |
| 19. RESERVED FOR LOCAL   | JSE   |                   |   |  | •                               |  | 20. OUTSIDE                             |                    | <u> </u>             |                       | \$ CHAI            |                  |   |
| 21. DIAGNOSIS OR NATURE  | OF ILLNESS O  | IR INJUR          | Y. (RELATE ITEM   | S 1,2,3 OR 4 TO I                          | TEM 24E BY LIN                  | Ε)                                     | 22. MEDICAID                            | RESUB              | - 1                  | N OBJECT              |                    |                  |   |
| 1. L <b>V202</b> .   |   |                   |   | 3  | _                               | +                                      | CODE<br>23. PRIOR AL                    | THORIZ             | ATIONA               |                       | INAL RE            | EF. NU.          | •   |
| 2. L <b>460</b>  |   |                   |   | 4  | -                               |  | 25.1711011740                           | 11101112           | Anoiti               | TOMBEN                |                    |                  |   |
| DATE(S) OF SER   | ICE <sub>To</sub>   | Place<br>of       |   | D<br>URES, SERVICES<br>plain Unusual Circu |                                 | E<br>DIAGNOSIS                         | F                                       |                    | G<br>DAYS<br>OR      | H<br>EPSDT<br>Family  |                    | J                | K<br>RESERVED FOR                           |
| MM DD YY MM  | 4   | Service           | Service CPT/HC  | PCS   MODII                                | FIER                            | CODE                                   | \$ CHARG                                |                    | UNITS                | Plan                  | EMG                | СОВ              | LOCAL USE                                   |
| 12   | 09 <u>03</u><br>09 03   | 1                 | 993<br>870  |  |                                 |  | 80<br>12                                |                    | 1                    | R                     |                    |                  |   |
|  | <u> </u>  | -                 |   | 1 1  |                                 |  |   |                    |                      |                       | _                  |                  |   |
|  | 09; 03  | 11                | 991   | 72 EP                                      |                                 |  | 0                                       | 00                 | 1                    |                       |                    |                  |   |
| 12 09 03 12  | 09  03  | 11                | 925   | 51   EP                                    |                                 |  | 0                                       | 00                 | 1                    |                       |                    |                  |   |
| 12 09 03 12<br>12 09 03 12   |   |                   |   | 1 1  |                                 |  |   |                    |                      |                       |                    |                  |   |
|  |   |                   |   |  |                                 |  | -                                       |                    |                      | -                     | -                  |                  |   |
|  |   |                   |   | 1  |                                 | PT ASSIGNMENT?<br>t. claims, see back) | 28. TOTAL CH                            | ARGE               | 120                  | 9. AMOU               | NT PAI             | _                | 30. BALANCE DUE                             |
|  |   | EIN               | 26. PATIENT'S   | ACCOUNT NO.                                | 27 ACCEP                        |  | \$                                      | 92 4               | 43 5                 | 1                     | 1                  |                  | s 92 43                                     |
| 12 09 03 12  | ER SSN  |                   |   |  | YES                             | NO                                     |   |                    |                      |                       |                    | , ADDR           |   |
| 12 09 03 12 25 FEDERAL TAX I D NUMB 31 SIGNATURE OF PHYSICI INCLUDING DEGREES (I) Cortily that the statement   | ER SSN IN OR SUPPLIE I CREDENTIALS on the reverse                   | ER<br>S           | 32. NAME AND  |  | YES<br>ACILITY WHERE            | NO SERVICES WERE                       | 33. PHYSICIAN<br>& PHONE                |                    |                      | e P                   |                    | ide              | r   |
| 12 09 03 12  | ER SSN IN OR SUPPLIE I CREDENTIALS on the reverse                   | ER<br>S           | 32. NAME AND  | ADDRESS OF FA                              | YES<br>ACILITY WHERE            | NO                                     | 33. PHYSICIAN<br>& PHONE                | Dr.                | . Jo                 | e P                   | rov<br>der         | St               | reet  |
| 12 09 03 12 25. FEDERAL TAX I D NUMB 31. SIGNATURE OF PHYSICI INCLUDING DEGREES (I) Certify that the statement | ER SSN IN OR SUPPLIE I CREDENTIALS on the reverse de a part thereof | ER<br>S           | 32. NAME AND<br>RENDERED                                  | ADDRESS OF FA                              | YES<br>ACILITY WHERE            | NO                                     | 33. PHYSICIAN<br>& PHONE I              | Dr<br>11<br>Pro    | . Jo                 | e P<br>ovider '       | rov<br>der         | St<br>n, 1       | reet<br>NC 12345                            |

| DO NOT   |  |  |  |  |  | rivate Prov   |  |  |  |   |   |
|--|--|--|--|--|--|---|--|--|--|---|---|
| STAPLE<br>IN THIS<br>AREA  |  |  |  |  | 0  | eriodic Scr<br>eferral Ind  |  |  |  |   |   |
|  |  |  |  |  | °In  | munization  | ıs   |  |  |   |   |
| 1. MEDICARE MEDICA   | ND CH  | AMPUS  | CHAMPVA  | CDOUD F  | CC4 0714   | SURANCE C   |  |  |  | FOR F   | PICA PROGRAM IN ITEM  |
| (Medicare #) (Medicare   |  | onsor's SSN)<br>Middle Initia  | 1-mil  | 3 PATIENT'S BIRTH DATE   | ILK LUNG<br>(SSN) (ID)   | 111111<br>4. INSURED'S NAME   |  |  | t Name   | Middle  | a Initial)  |
| Recipient, Jo  | oe   |  |  | 09 06 2001   |  |   |  |  |  |   |   |
| 5. PATIENT'S ADDRESS (No.,   |  | et   |  | 6. PATIENT RELATIONSHIP Self Spouse Ch   |  | 7. INSURED'S ADDRE  | ESS (No  | ., Street  | )  |   |   |
| Recipient To   |  |  | STATE<br>NC  | 8. PATIENT STATUS Single Married   | Other  | CITY  |  |  |  |   | STATE   |
| ZIP CODE   | TELEPHO  | NE (Include A  | (rea Code)   | Employed Full-Time   | Part-Time  | ZIP CODE  |  | TEL  | EPHONE   | (INC  | LUDE AREA CODE  |
| 9. OTHER INSURED'S NAME (  |  | 999-<br>st Name, Mic   |  | 10. IS PATIENT'S CONDITIO  | Student  | 11. INSURED'S POLIC   | Y GRO  | UP OR I  | ECA NU   | )<br>MBEF   |   |
| a. OTHER INSURED'S POLICY  | OR GROUP   | IUMBER   |  | a. EMPLOYMENT? (CURREN   | IT OR PREVIOUS)  | a. INSURED'S DATE   | OF BIRT  | н  |  |   | SEX   |
| b. OTHER INSURED'S DATE O  |  |  | ****   | YES  | NO PLACE (State)   | a. INSURED'S DATE O   | <u>i</u>   |  | М  |   | F _   |
| MM DD YY   | м  | SEX  |  | b. AUTO ACCIDENT?  | NO   |   |  |  |  |   |   |
| c. EMPLOYER'S NAME OR SCI  | HOOL NAME  |  |  | c. OTHER ACCIDENT?   | NO   | c. INSURANCE PLAN   | NAME   | OR PRO   | GRAM N   | AME   |   |
| d. INSURANCE PLAN NAME O   | R PROGRAM  | NAME   |  | 10d. RESERVED FOR LOCAL  | . USE  | d. IS THERE ANOTHE  |  |  |  |   |   |
| READ<br>12. PATIENT'S OR AUTHORIZE   | D BACK OF FO   | ORM BEFOR  | E COMPLETING   | G & SIGNING THIS FORM.   | nformation necessary   | 13. INSURED'S OR AU   | JTHORI   | ZED PE   | RSON'S   | SIGNA   | omplete item 9 a-d.   |
| to process this claim. I also re<br>below.   | equest paymen  | t of governme  | ent benefits either  | r to myself or to the party who acc  | cepts assignment   | payment of medica<br>services described   | below.   | s to the t   | undersign  | iea prij  | ysician or supplier it  |
| SIGNED   |  |  |  | DATE   |  | SIGNED  |  |  |  |   |   |
| MM DD YY   | LLNESS (First<br>NJURY (Accide<br>PREGNANCY(I  | ent) OR<br>.MP)  |  |  | R SIMILAR ILLNESS<br>0 : 0000                                      | 16. DATES PATIENT L<br>MM   DD<br>FROM  | NABLE<br>YY  | to wo  | RK IN CL<br>TO   | JRREN<br>MM   | NT OCCUPATION   |
|  |  | THER COLL  |  |  |  | 171014  | - 1  |  |  |   | ! !   |
| 17. NAME OF REFERRING PH   | YSICIAN OR C   | THER SOUR  | RCE 17a  | . I.D. NUMBER OF REFERRING   |  | 18. HOSPITALIZATION<br>MM   DD<br>FROM  | DATE   | S RELAT  | ED TO C  | URRE  |   |
| 19. RESERVED FOR LOCAL US  |  | THER SOUR  | ACE 17a  | . I.D. NUMBER OF REFERRING   |  | 18. HOSPITALIZATION MM   DD FROM   20. OUTSIDE LAB?   | DATE   | S RELAT  | ED TO C  | URRE<br>MM  | ENT SERVICES  |
|  | SE   |  |  |  | S PHYSICIAN  | 18. HOSPITALIZATION MM   DD FROM   20. OUTSIDE LAB? YES   | DATE:  | S RELAT  | ED TO C  | MM<br>GES   | ENT SERVICES<br>DD YY   |
| 19. RESERVED FOR LOCAL US  | SE   |  | RELATE ITEMS   |  | S PHYSICIAN  | 18. HOSPITALIZATION MM   DD FROM   20. OUTSIDE LAB?   | NO MISSIO  | N ORIG   | ED TO C<br>TO<br>\$ CHAR<br>SINAL RE   | MM<br>GES   | ENT SERVICES<br>DD YY   |
| 19 RESERVED FOR LOCAL US 21. DIAGNOSIS OR NATURE O 1 LV20.2 2 L382.9   | SE   | R INJURY. (F   | RELATE ITEMS   | 1.2,3 OR 4 TO ITEM 24E BY LIN  | S PHYSICIAN  | 18. HOSPITALIZATION FROM D  20. OUTSIDE LAB? VES 22. MEDICAID RESUB CODE  23. PRIOR AUTHORIZ  | NO MISSIO  | N ORIG   | TO S CHAR  | GES<br>F. NO  | ENT SERVICES<br>DD YY   |
| 19 RESERVED FOR LOCAL US  21. DIAGNOSIS OR NATURE O  1 LV20.2  2 L382.9  24 A  DATE(S) OF SERVICE  FROM  | SE  OF ILLNESS OF  CETO  | B (Place Type  | RELATE ITEMS  4 C pp PROCEDUR 4 (Expla   | 1,2,3 OR 4 TO ITEM 24E BY LIN 3  | (E)  | 18. HOSPITALIZATION MM   DD FROM   20. OUTSIDE LAB?  YES   22. MEDICAID RESUB CODE  | NO MISSIO ATION I  | N ORIG   | TO S CHAR  | MM<br>GES   | ENT SERVICES<br>DD YY   |
| 19. RESERVED FOR LOCAL US  21. DIAGNOSIS OR NATURE O  1. LV202  2. L3829  24A  | SE  OF ILLNESS OF  DE TO YY  | B (Place Tylof of Service Sen  | RELATE ITEMS  4 C   PROCEDUR   | 1.2,3 OR 4 TO ITEM 24E BY LIN 3. L. D. OR SUPPLIES in Unusual Circumstances) S. J. MODIFIER                | E DIAGNOSIS  | 18. HOSPITALIZATION FROM M   DD FROM M   DD 20. OUTSIDE LAB? VES   VES   CODE 22. MEDICAID RESUB CODE 23. PRIOR AUTHORIZ  | NO MISSIO ATION I  | N ORIG   | TO S CHAR  | IGES<br>F. NO   | ENT SERVICES DD YY YY  KESERVED FOR   |
| 19. RESERVED FOR LOCAL US  21. DIAGNOSIS OR NATURE O  1  | SE  OF ILLNESS OF Illn | B (CPlace Tyrof Service Servic | PROCEDURA (Expla   | 1,2,3 OR 4 TO ITEM 24E BY LIN 3. L   | E DIAGNOSIS  | 18. HOSPITALIZATION FROM DO PROM DO 20 OUTSIDE LAB? VES 22 MEDICAID RESUB CODE 23 PRIOR AUTHORIZ F \$ CHARGES   | NO MISSIO ATION I  | N ORIG   | TO S CHAR  | IGES<br>F. NO   | ENT SERVICES DD YY YY  KESERVED FOR   |
| 19. RESERVED FOR LOCAL US  21. DIAGNOSIS OR NATURE O  1 LV202  2 L3829  24 A  POATE(S) OF SERVICE MM DD YY MM  11 22 03 11 1  11 22 03 11  | SE  CE <sub>TO</sub> DD W  22 03  22 03  | B (Place Tylor Service | PROCEDUR (Expla cPT/HGPC 99392 90471   | I. 2,3 OR 4 TO ITEM 24E BY LIN B. L  | E DIAGNOSIS  | 18. HOSPITALIZATION FROM DO DE  | MISSIO ATION I  G DAYS OR UNITS  1   | N ORIG   | TO S CHAR  | IGES<br>F. NO   | ENT SERVICES DD YY YY  KESERVED FOR   |
| 19. RESERVED FOR LOCAL US  21. DIAGNOSIS OR NATURE O  1  | DE TO THE T  | B (Place Tyrof Service | PROCEDUR    | 1,2,3 OR 4 TO ITEM 24E BY LIN 3. L   | E DIAGNOSIS  | 18. HOSPITALIZATION FROM DO DE  | N DATE: YY   | N ORIG   | TO S CHAR  | IGES<br>F. NO   | ENT SERVICES DD YY YY  KESERVED FOR   |
| 19. RESERVED FOR LOCAL US  21. DIAGNOSIS OR NATURE O  1 LV202  2 L 3829  24 A  FIGURE 1 (S) OF SERVICE  MM DD YY MM  11 22 03 11  11 22 03 11  11 22 03 11   | SE  DF ILLNESS OF 12 12 12 12 12 12 12 12 12 12 12 12 12   | B (Place Tylor Service | PROCEDUR (Expla cPT/HGPC 99392 90471   | 1,2,3 OR 4 TO ITEM 24E BY LIN 3. L   | E DIAGNOSIS  | 18. HOSPITALIZATION FROM DO DE  | MISSIO ATION I  G DAYS OR UNITS  1   | N ORIG   | TO S CHAR  | IGES<br>F. NO   | ENT SERVICES DD YY YY  KESERVED FOR   |
| 19. RESERVED FOR LOCAL US  21. DIAGNOSIS OR NATURE O  1  | SE  DF ILLNESS OF 12 12 12 12 12 12 12 12 12 12 12 12 12   | B (Place Tyrof Service | PROCEDUR    | 1.2.3 OR 4 TO ITEM 24E BY LIN  D  D  RES, SERVICES, OR SUPPLIES IN Unusual Circumstances) 2 EP  L EP  2 EP | E DIAGNOSIS  | 18. HOSPITALIZATION FROM DO DE  | N DATE: YY   | N ORIG   | TO S CHAR  | IGES<br>F. NO   | ENT SERVICES DD YY YY  KESERVED FOR   |
| 19 RESERVED FOR LOCAL US  21. DIAGNOSIS OR NATURE O  1 LV20_2  2 L 382_9  24 A  10 DATE(S) OF SERVIC  MM DOD VY MM  11 22 03 11  11 22 03 11  11 22 03 11  11 22 03 11  11 22 03 11  | DE <sub>TO</sub> VY 22 03 22 03 22 03 22 03 22 03 22 03 22 03  | B C Place Typ of Post Post Post Post Post Post Post Post   | 99392 90471 90645 90665  | 1,2,3 OR 4 TO ITEM 24E BY LIN 3. L   | E DIAGNOSIS CODE   | 18. HOSPITALIZATION FROM 1 DD 20. OUTSIDE LAB? 22. MEDICAID RESUB CODE 23. PRIOR AUTHORIZ  F S CHARGES  80 33  13 71  13 71  0 00  0 00  0 00   | NO ATE: YYY  NO   MISSIO   ATION   I   I   I   I   I   I   I   I   I   | N ORIG   | TO TO SCHAR  | J<br>COB  | K RESERVED FOI LOCAL USE  |
| 19. RESERVED FOR LOCAL US  21. DIAGNOSIS OR NATURE O  1 LV202  2 L 3829  24.   | CE <sub>TO</sub> VY 22 03 22 03 22 03 22 03 22 03 22 03  | B C Place Tyl Service Sen 11 11 11 11 11 11 11 11 11 11 11 11 11   | PRICE OF PROCEDURE (Explanation of Carping Processing P | 1,2,3 OR 4 TO ITEM 24E BY LIN 3, L   | E DIAGNOSIS  | 18. HOSPITALIZATION FROM M DO   | NO MISSION MISSION OR OR ON ON THE TENT OF | N ORIG   | TO S CHAR  | J<br>COB  | ENT SERVICES DD YY YY  KESERVED FOR   |
| 19. RESERVED FOR LOCAL US  21. DIAGNOSIS OR NATURE O  1 LV202  2 L 3829  24  | CETO WY 22 03 22 03 22 03 22 03 22 03 22 03 22 03  | B C Place Tyr of | PROCEDURA   100    | 1,2,3 OR 4 TO ITEM 24E BY LIN 3, L   | PHYSICIAN  E  DIAGNOSIS CODE  PT ASSIGNMENT? VI. Claims, see back) | 18. HOSPITALIZATION FROM M DO 20. OUTSIDE LAB7 22. MEDICAID RESUB CODE 23. PRIOR AUTHORIZ 24. PRIOR AUTHORIZ 25. TOTAL CHARGE 26. TOTAL CHARGE 27. PRISCIANS, SUP.  | NO MISSIO ATTION II  ATTION II  1  1  1  1  1  1  1  1  1  1  1  1   | N ORIGINAL NAME OF THE PROPERTY OF THE PROPERT | TO TO S CHARACTER TO  | ADDE  | K RESERVED FOI LOCAL USE  30. BALANCE DUI \$ 107;                                   |
| 19. RESERVED FOR LOCAL US  21. DIAGNOSIS OR NATURE O  1 LV20_2  2 L 382_9  24 A  DATE(S) OF SERVICE  MM DD YY MM  11 22 03 11  11 22 03 11  11 22 03 11  11 22 03 11  11 22 03 11  11 22 03 11  11 22 03 11  11 22 03 11  11 22 03 11  11 32 03 | DE TO THE PRINCIPLE OF  | B C Place Typ of Post Post Post Post Post Post Post Post   | PROCEDURA   100    | 1.2.3 OR 4 TO ITEM 24E BY LIN  3.  | PHYSICIAN  E  DIAGNOSIS CODE  PT ASSIGNMENT? VI. Claims, see back) | 18. HOSPITALIZATION FROM 1 DD 20. OUTSIDE LAB? 22. MEDICAID RESUB CODE 23. PRIOR AUTHORIZ 23. PRIOR AUTHORIZ 24. ACTUAL CHARGES 25. ACTUAL CHARGES 26. TOTAL CHARGES 27. ACTUAL CHARGES 28. TOTAL CHARGES 29. PHYSICIAN'S, SUPA PHONE 7 DT 11 | NO MISSION IN ARTION II  ARTION II  1  1  1  1  1  1  1  1  1  1  1  1   | N ORIGINUMBER H EPSDT Family Plan R S 6 BILLINIA   | TO S CHARLES S C | DECORPTION OF THE PROPERTY OF | K RESERVED FOI LOCAL USE  30. BALANCE DUI \$ 107; AESS, ZIP CODE                    |
| 19. RESERVED FOR LOCAL US  21. DIAGNOSIS OR NATURE O  1 LV20_2  2 L 382_9  24 A  10 DATE(S) OF SERVIC  MM DD YY MM  11 22 03 11  11 22 03 11  11 22 03 11  11 22 03 11  11 22 03 11  11 22 03 11  11 22 03 11  11 22 03 11  11 32 03 11  11 32 03 11  11 32 03 11  11 32 03 11  11 32 03 11  11 32 03 11  11 32 03 11  11 32 03 11  11 32 03 11  11 32 03 11  11 32 03 11  11 32 03 11  11 32 03 11  11 32 03 11  11 32 03 11  | DE TO THE TOTAL TOT | B C Place Typ of Post Post Post Post Post Post Post Post   | 99392 90471 90645 90666 90713 90666 22 NAME AND A RENDERED (   | 1.2.3 OR 4 TO ITEM 24E BY LIN  3.  | PHYSICIAN  E  DIAGNOSIS CODE  PT ASSIGNMENT? VI. Claims, see back) | 18. HOSPITALIZATION FROM 1 DD 20. OUTSIDE LAB? 22. MEDICAID RESUB CODE 23. PRIOR AUTHORIZ 23. PRIOR AUTHORIZ 24. ACTUAL CHARGES 25. ACTUAL CHARGES 26. TOTAL CHARGES 27. ACTUAL CHARGES 28. TOTAL CHARGES 29. PHYSICIAN'S, SUPA PHONE 7 DT 11 | NO MISSION IN ARTION IN ARTION IN ARTION IN  | N ORIGINUMBER HEPSDT Family Plan R 9 AMOU  | TO S CHARLES S C | J COB ADDREVICE Str.,   | K RESERVED FOI LOCAL USE  30. BALANCE DUI \$ 107; RESS, ZIP CODE  Ger L'eet NC 1234 |

| MEALTH INSURANCE CLAIM FORM   100 CHAMPUS   100 FRO 3  | PLEASE<br>DO NOT<br>STAPLE<br>IN THIS<br>AREA   |                                |          |               |  | °]                        | Private Pr<br>Periodic S<br>Immunizati         | creeni         | ng.                 |                     |  |
|--|---|--------------------------------|----------|---------------|--|---------------------------|--|----------------|---------------------|---------------------|--|
| Microsoff   Micr   | PICA  |                                |          |               |  | HEALTH                    | INSURANCE                                      | CLAIM          | EO DI               | N/I                 |  |
| PATENTS NAME (   |   |                                |          | -             | GROUP<br>HEALTH PLAN                               | EECA OT                   | HER 14 INSURED'S !!                            | NUMBER         |                     |                     |  |
| 111   Recipient Street   | 2 PATIENT'S NAME (Last Name)  |                                |          |               |  |                           |  |                |                     | ame Mic             | adie inita'                              |
| 11   Recipient Street  | Recipient, Joseph S PATIENT'S ADDRESS IND. SIN  | eet,                           |          |               |  |                           | 7 INSUREDIS AD                                 | DRESS A.S.     | treat               |                     |  |
| Recipient Toon   NC   Single   Market   Direct   Market   Direct   Market   Direct   | 111 Recipient   | Street                         |          | CTATE         |  | Ohild Other               | -  | 0112301140.0   | mee.                |                     |  |
| 20   12345   12345   12345   12346     |   |                                |          | NC            | Į.   | . Other                   | CiTY   |                |                     |                     | STATE                                    |
| Content insured Strame   Fight Name   Made innoval   | 1   |                                |          |               | Employed - Full-Tim                                |                           | ZIP CODE                                       |                | TELEPH              | IONE (IN            | NOLUDE AREA COD                          |
| STATE   COLUMN   CO   |   |                                |          |               | Student<br>10 IS PATIENT'S CONDIT                  | Student<br>ION RELATED TO | 11 INSURED S PC                                | LICY GROUP     | OR FECA             | NUMB                | ER                                       |
| Ves  | a OTHER INSURED'S POLICY OR   | GROUP NUM                      | BER      |               | a EMPLOYMENT? (CURR                                |                           | a INSURED'S DAT                                | FOFBIRTH       |                     |                     |  |
| MM   | D OTHER INSURED'S DATE OF BU  | IRTH                           |          |               |  |                           |  |                |                     | м                   |  |
| 10   INSURANCE PLAN NAME OF PROGRAM NAME   VES   NO     C   INSURANCE PLAN NAME OF PROGRAM NAME   C   INSURANCE PLAN NAME OF PROGRAM OF OTHER PROGRAM    | MM DD YY  | м                              |          |               |  |                           | el b. EMPLOYER'S N.                            | AME OR SCHO    | OOL NAM             | E                   |  |
| DATE   100 RESERVED FOR LOCAL USE   0 IS THERE ANOTHER HEALTH BENEFIT PLAN'   VEST NOW   1 Was return to an accordance with 5 and 1 to complete them 5 and 1 to complete them 5 and 1 to complete them 5 and 1 to the com   | c. EMPLOYER'S NAME OR SCHOOL  | DL NAME                        |          |               |  | - NO                      | c INSURANCE PLA                                | IN NAME OR I   | PROGRAM             | M NAME              |  |
| 12 PATENTS OR AUTHORIZED PRISONS SIGNATURE Is authorized the signal of the individual property of the property | G INSURANCE PLAN NAME OR PE   | ROGRAM NAM                     |          |               |  |                           | c. IS THERE ANOTI                              | HER HEALTH     | BENEFIT             | PLANS               |  |
| SIGNED   DATE   SIGNAL CHERNY   COUNTY   COUNT   | READ BA   | CK OF FORM                     | BEFORE ( | COMPLETING    | & SIGNING THIS FORM.                               |                           |  |                | yes retur           | n to and            | complete item 9 a-d                      |
| 1  | 14 DATE OF CURRENT INJUR  | RY (Accident) O<br>SNANCY(LMP) | R        |               | PATIENT HAS HAD SAME OF FIRST DATE MM 11 1         | Ϊ 1111                    | S. 16 DATES PATIENT<br>MM D                    |                | LATED TO            | O CURR              |  |
| 21   | . 19 RESERVED FOR LOCAL USE   |                                |          |               |  |                           | 20 OUTSIDE LAB?                                |                |                     |                     |  |
| 2 L 2  | 21. DIAGNOSIS OR NATURE OF ILL  | NESS OR INJU                   | IRY (REL | ATE ITEMS 1.2 | 3 OR 4 TO ITEM 24E BY LIF                          | νE, ———                   | _ 1  | BMISSION       |                     |                     |  |
| S  | ± ∠V202   |                                |          | 3. 1          |  | *                         |  |                |                     | HEF NO              | )  |
| Part      | 2   |                                |          | 4 [           |  | _                         | ES THIST ACTION                                | ZATION NOM     | ic n                |                     |  |
| 12 10 03 12 10 03 11   99381   EP  |   | Place                          | Type     | PROCEDURES    | SERVICES OR SUPPLIES                               | DIAGNOSIS                 |  | DAYS EPS       | DTI                 | 1                   | K<br>RESERVED FOR                        |
| 12 10 03 12 10 03 11 90471 EP 13 71 1  12 10 03 12 10 03 11 90472 EP 13 71 1  12 10 03 12 10 03 11 90744 0 0 00 1  12 10 03 12 10 03 11 90700 0 0 0 1  12 10 03 12 10 03 11 90700 0 0 0 1  13 FEDERAL TAX ID NUMBER SSN EIN 26 PATIENT S ACCOUNT NO 27 ACCEPT ASSIGNMENT (PDI 9001 Clam No 1   |   |                                |          |               | 1  | CODE                      |  | UNITS Pla      |                     | СОВ                 |  |
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| 12 10 03 12 10 03 11 90700 0 0 0 0 1  5 FEDERAL TAX ID NUMBER SSN EIN 26 PATIENT'S ACCOUNT NO 27 ACCEPT ASSIGNMENT' (Fird good cluims see back) (Fird good cluims see back)  1 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (Locetly mat the statements on the reverse apply to this bill and are made a part mereot.)  32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE 33 PHYSICIAN S. SUPPLIER'S BILLING NAME. ADDRESS. ZIP CODE A PHONE .  A PHONE .  5 TOTAL CHARGE 29 AMOUNT PAID 30 BALANCE DUE 25 AMOUNT PAID 30 BALANCE DUE 25 AMOUNT PAID 31 BALANCE DUE 25 AMOUNT PAID 32 PHYSICIAN S. SUPPLIER'S BILLING NAME. ADDRESS. ZIP CODE A PHONE .  5 TOTAL CHARGE 29 AMOUNT PAID 30 BALANCE DUE 25 AMOUNT PAID 30 BALANCE DUE 25 AMOUNT PAID 31 BALANCE DUE 25 AMOUNT PAID 32 BALANCE DUE 25 AMOUNT PAID 32 BALANCE DUE 25 AMOUNT PAID 31 BALAN | 12 10 03 12 10  | 03   11                        |          | 90472         | EP   |                           | 13 71  | 1              |                     |                     |  |
| 12 10 03 12 10 03 11 90700 0 0 00 1  5 FEDERAL TAX ID NUMBER SSN EIN 26 PATIENT'S ACCOUNT NO 27 ACCEPT ASSIGNMENT (FOI 90x) claims see Dach (FOI 90x | 12 10 03 12 10  | 03   11                        |          | 90744         | 1  |                           | 0 00   | 1              |                     |                     |  |
| 5 FEDERAL TAX ID NUMBER SSN EIN 26 PATIENTS ACCOUNT NO 27 ACCEPT ASSIGNMENT? 160 gowl claims see bach 2 5 107 75 5 5 107 75 107  | 12 10 03 12 10  | 03 11                          |          | 00700         | 1  |                           |  |                |                     |                     |  |
| SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS ILCOMING MAINTENS OF DATE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS ILCOMING MAINTENS OF DATE OF PHYSICIAN S. SUPPLIERS SILLING NAME. ADDRESS. ZIP CODE A PHONE OF THE PROVIDER SILLING NAME. ADDRESS. ZIP CODE A PHONE OF THE PROVIDER SILLING NAME. ADDRESS. ZIP CODE The provider of the Provider Street  Provider Town, NC 12345   | .2 10 05 12 10  | <u> 11</u>                     |          | <i>30100</i>  |  |                           | 0 00   | 1              | -                   |                     |  |
| Signature of Physician of Supplier   Signature of Pile   Si   | 5 FEDERAL TAX I.D NUMBER  | SSN EIN                        | 26 PA    | ATIENT'S ACCO | DUNTINO 27 ACCES                                   | TASSIGNMENTS              | 26 TOTAL CUADO:                                |                |                     |                     |  |
| INCLUDING DEGREES OR CREDENTIALS  32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE A PHONE IS BILLING NAME ADDRESS. IP CODE RENDERED (If other than nome or office  Signature on File  GNED  DATE 12/24/02  | SIGNATURE OF BUVE COMMON  | LIBRITIES                      |          |               | For gov<br>YES                                     | NO                        |  | 1              | JUNT PAI            | ID                  |  |
|  | including Degrees or Crede it certify that the statements on the in apply to this bill and are made a part  Signature on Fi | everse<br>thereof.)            | RE       | MOERED (II OR | RESS OF FACILITY WHERE<br>ner than home or office- |                           | 33 PHYSICIANS, SUP<br>& PHONE * Dr<br>11<br>Pr | Jane<br>1 Prov | Rec<br>rider<br>Tow | cipi<br>s St<br>vn, | ess, zip code<br>ent<br>reet<br>NC 12345 |

| N THIS AREA PIG  | DA<br>ARE                                | MEDIC.   |   |  | IMPUS   | _   | HAMPVA  | HEALTH PLAN  | °P.  | mmunizatio<br>aper bille<br>INSURANCE   | rs (                                 | only  | /sp      | lit<br>M                    | cla          |               |
|--|--|--|---|--|---|---|---|--|--|---|--------------------------------------|---|----------|-----------------------------|--------------|---------------|
| Rec  | ipie                                     | E (Last Nar<br>ent,                            | Joe   | varne. I   | Middle II   | nitial)   |   | 3 PATIENT'S BIRTH DATE MM DD YY  |  | 33333<br>4 INSURED'S NA   | 333.<br>ME (Las                      | 3X<br>st Name.  | First Na | ame Mic                     | adle initia: |               |
| 111  |  | RESS (No                                       |   | tre  | et  |   |   | 6 PATIENT RELATIONSH   | IP TO INSURED Onlid Other                        | INSURED'S AD  | DAESS                                | iNo . Str   | eet      |                             |              |               |
| Rec  | inie                                     | ent To   | )W7)  |  |   |   | STATE<br>NC:  | 8 PATIENT STATUS Single Married  |  | CITY  |                                      |   |          |                             |              | STATE         |
| ZIP CODE   |  |  | TELE  |  |   | e Area Code   | e;  |  | Other  | ZIP CODE  |                                      | Т   | TELEPH   | IONE (II                    | VCLUDE A     | AREA CODE     |
|  |  | S NAME (                                       | ast Nam   | クソ)<br>e. First  | Name.   | -9999<br>Middle Initia  | <b>)</b><br>I)  | Student<br>10 IS PATIENT'S CONDIT  | Student  | 11 INSURED'S PC   | LICY G                               | ROUP O  | R FECA   | )<br>A NUMB                 | ER           |               |
| a. OTHER II  | NSURE                                    | S POLICY                                       | OR GRO  | UP NU  | MBER  |   |   | a. EMPLOYMENT? (CURRE  | ENT OR PREVIOUS                                  |   |                                      |   |          |                             |              |               |
| b. OTHER I   | VSURED                                   | S DATE O                                       | BIRTH   |  | SEX   |   |   | YES  | NO   | MM  |                                      |   |          | м                           | SEX          | F             |
| c. EMPLOYE   | D Y                                      | ·  |   | м — .  | JLA   | F   |   | YES  | PLACE (Sta                                       | b EMPLOYERS N   | AME OF                               | SCHOO   | DL NAM   | E                           |              |               |
|  |  |  |   |  |   |   |   | c OTHER ACCIDENT? YES  | <sub>NO</sub>                                    | s. INSURANCE PLA  | AN NAM                               | E OR PR   | OGRAN    | M NAME                      |              |               |
| d INSURAN  | CE PLAI                                  | NAME OF  | PROGR   | AM NA  | ME  |   | $\neg$  | 10d. RESERVED FOR LOCA   |  | d IS THERE ANOTH  | HER HE                               | ALTH BE   | NEFIT    | PLAN?                       |              |               |
| SIGNED   | CUBBE                                    | NT: / ILI                                      | NESS (F   | ırst syr   | nptom)  | OB  | lie is  | DATE   |  | SIGNED  |                                      |   |          |                             |              |               |
| 14. DATE OF MM DI 17 NAME OF 19. RESERVE   | REFER                                    | RING PHYS                                      | EGNANO  | я отн  | OR<br>ER SOL  | JACE  | 17a I I   | PATIENT HAS HAD SAME OF REFERRING  NUMBER OF REFERRING  3 OR 4 TO ITEM 24E BY LIN  | 3 PHYSICIAN                                      | S. 16 DATES PATIENT FROM  18 HOSPITALIZATIO FROM  20 OUTSIDE LAB? YES   | DN DAT.<br>D Y                       | ES RELA   | TED TO   | CURR                        | RENT SER     |               |
| 17 NAME OF 19. RESERVE 21. DIAGNOS 1. LV20 2. L  | REFER                                    | RING PHYS                                      | EGNANO  | OR IN  | OR<br>ER SOL  | JACE  | 17a I I   | O NUMBER OF REFERRING  | 3 PHYSICIAN                                      | S. 16 DATES PATIENT FROM D 18 HOSPITALIZATION FROM D 20 OUTSIDE LAB?  | NO BMISSH                            | ON ORK  | S CH     | O CURR<br>MM<br>O<br>ARGES  | BENT SER     |               |
| 17 NAME OF  19 RESERVE  21 DIAGNOS  1  | D FOR                                    | RING PHYS                                      | LLNESS  | OR IN  | OR<br>ER SOU  | RELATE ITS  | 17a III<br>EMS 1.2.<br>3. L<br>4. L                         | D NUMBER OF REFERRING 3 OR 4 TO ITEM 24E BY LIN  | B PHYSICIAN  E  DIAGNOSIS                        | 5 16 DATES PATIENT FROM MM D 18 HOSPITALIZATI FROM 20 OUTSIDE LAB? YES 22 MEDICAID RESU CODE 23 PRIOR AUTHORI.  | NO<br>BMISSH<br>ZATION               | ON ORK  | S CHA    | O CURRE<br>MM<br>O<br>ARGES | DD D         | VICES         |
| 17 NAME OF 19. RESERVE 21. DIAGNOS 1. LV20 2. L  | D FOR                                    | PAING PHYS  LOCAL USE  ATURE OF  F SERVICE  MM | LLNESS  | OR IN  | JURY. (   | RELATE ITE  | 17a III EMS 1.2. 3. L 4. L EDURES EXplain L ICPCS           | D NUMBER OF REFERRING  3 OR 4 TO ITEM 24E BY LIN  D  SERVICES, OR SUPPLIES  I MODIFIER   | G PHYSICIAN                                      | S 16 DATES PATIENT FROM MM D 18 HOSPITALIZATE FROM D 20 OUTSIDE LAB? YES 22 MEDICAID RESU CODE 23 PRIOR AUTHORI  5 CHARGES  | NO BMISSI                            | ON ORM  | S CH     | O CURR<br>MM<br>O<br>ARGES  | RESERVE      | VICES<br>YY   |
| 17 NAME OF  19. RESERVE  21. DIAGNOS  1. LV20  2 L  24 A  From  MM DD  11 01             | D FOR N . 2                              | ATURE OF                                       | LLNESS  | OR IN  | JURY. (   | RELATE ITE  | 17a 11  EMS 1.2. 3. L  4 L  EDURES Explain UniCPCS          | D NUMBER OF REFERRING  3 OR 4 TO ITEM 24E BY LIN  D  SERVICES. OR SUPPLIES Invasual Circumstances:  1 MODIFIER   | B PHYSICIAN  E  DIAGNOSIS                        | S 16 DATES PATIENT FROM MM D FROM MM D FROM | NO BMISSH ZATION  G DAYS OR          | ON ORM  | S CHA    | O CURRE<br>MM<br>O<br>ARGES | RESERVE      | K<br>RVED FOR |
| 17 NAME OF 19 RESERVE 21 DIAGNOS 1 LV20 2 L 24 A MM DD 11 01 11 01                       | D FOR IS OR N -2                         | F SERVICE                                      | ILLNESS   | OR IN OR IN OR IN OR IN  | OR PP) PER SOL  | RELATE ITE  | 17a 11  EMS 1.2. 3. L  4. L  EDURES Explain L  HOPCS  73    | D NUMBER OF REFERRING  3 OR 4 TO ITEM 24E BY LIN  DE VICES, OR SUPPLIES INVOICES, OR SUPPLIES INVOICES IN MODIFIER  EP   | B PHYSICIAN  E  DIAGNOSIS                        | S 16 DATES PATIENT FROM MM D 18 HOSPITALIZATE FROM D 20 OUTSIDE LAB? YES 22 MEDICAID RESU CODE 23 PRIOR AUTHORI  5 CHARGES  | NO BMISSI                            | ON ORM  | S CHA    | O CURRE<br>MM<br>O<br>ARGES | RESERVE      | K<br>RVED FOR |
| 17 NAME OF  19. RESERVE  21. DIAGNOS  1 LV20  2 L  24 A  From MM DD  11. 01              | D FOR IS OR N -2                         | ATURE OF                                       | ILLNESS   | OR IN OR IN OR IN OR IN  | OR PP) PER SOL  | RELATE ITE  | 17a 11  EMS 1.2. 3. L  4. L  EDURES Explain L  HOPCS  73    | D NUMBER OF REFERRING  3 OR 4 TO ITEM 24E BY LIN  D  SERVICES. OR SUPPLIES Invasual Circumstances:  1 MODIFIER   | B PHYSICIAN  E  DIAGNOSIS                        | S 16 DATES PATIENT FROM MM D FROM MM D FROM | NO BMISSIN G DAYS OR UNITS           | ON ORM  | S CHA    | O CURRE<br>MM<br>O<br>ARGES | RESERVE      | K<br>RVED FOR |
| 17 NAME OF 19 RESERVE 21 DIAGNOS 1 LV20 2 L 24 A MM DD 11 01 11 01                       | D FOR IS OR N -2                         | F SERVICE                                      | ILLNESS   | OR IN OR IN OR IN OR IN  | OR PP) PER SOL  | RELATE ITE  | 17a 11  EMS 1.2. 3. L  4. L  EDURES Explain L  HOPCS  73    | D NUMBER OF REFERRING  3 OR 4 TO ITEM 24E BY LIN  DE VICES, OR SUPPLIES INVOICES, OR SUPPLIES INVOICES IN MODIFIER  EP   | B PHYSICIAN  E  DIAGNOSIS                        | S 16 DATES PATIENT FROM MM D 18 HOSPITALIZATION DE PROM D 20 OUTSIDE LAB?  YES 22 MEDICAID RESU CODE 23 PRIOR AUTHORIC  5 CHARGES  80 33  | NO BMISSH ZATION  G DAYS OR UNITS  1 | ON ORM  | S CHA    | O CURRE<br>MM<br>O<br>ARGES | RESERVE      | K<br>RVED FOR |
| 17 NAME OF 19 RESERVE 21 DIAGNOS 1 LV20 2 L 24 A Prom MM DD 11 01 11 01                  | D FOR IS OR N -2                         | F SERVICE                                      | ILLNESS   | OR IN OR IN OR IN OR IN  | OR PP) PER SOL  | RELATE ITE  | 17a 11  EMS 1.2. 3. L  4. L  EDURES Explain L  HOPCS  73    | D NUMBER OF REFERRING  3 OR 4 TO ITEM 24E BY LIN  DE VICES, OR SUPPLIES INVOLVES IN MODIFIER  EP  EP   | B PHYSICIAN  E  DIAGNOSIS                        | S 16 DATES PATIENT FROM MM D 18 HOSPITALIZATION DE PROM D 20 OUTSIDE LAB?  YES 22 MEDICAID RESU CODE 23 PRIOR AUTHORIC  5 CHARGES  80 33  | NO BMISSH ZATION  G DAYS OR UNITS  1 | ON ORM  | S CHA    | O CURRE<br>MM<br>O<br>ARGES | RESERVE      | K<br>RVED FOR |
| 17 NAME OF 19. RESERVE 21. DIAGNOS 1. LV20 2. L. A. DIAGNOS 1. LV20 11. O1 11. O1 11. O1 | 03 03 03                                 | F SERVICE  MM  111 (                           | EGNANO  ILLNESS  ILLNESS  ILLNESS  ILLNESS  ILLNESS | OR IN OR IN OR IN OR IN  | OR P)   | RELATE ITE  | 17a III  EMS 1.2. 3 L 4 L  EDURES xplan L (ICPCS 93  73  52 | D NUMBER OF REFERRING  3 OR 4 TO ITEM 24E BY LIN  D. SERVICES, OR SUPPLIES INJURIES INTERPRETATION OF THE PROPERTY OF THE PROP | E DIAGNOSIS CODE                                 | S 16 DATES PATIENT FROM MM D 18 HOSPITALIZATION DE PROM D 20 OUTSIDE LAB?  YES 22 MEDICAID RESU CODE 23 PRIOR AUTHORIC  5 CHARGES  80 33  | NO BMISSH ZATION  G DAYS OR UNITS  1 | ON ORM  | S CHA    | O CURRE<br>MM<br>O<br>ARGES | RESERVE      | K<br>RVED FOR |
| 17 NAME OF 19 RESERVE 21 DIAGNOS 1 LV20 24 A DAM DD 11 01 11 01                          | REFER D FOR N . 2 TE(S) O YY O 3 O 3 O 3 | F SERVICE MM 111 ( 111 (                       | EGNANO O  | OR IN  OR | ORPOSITION OF THE PROPERTY OF | PROCE | 17a i i i i i i i i i i i i i i i i i i i                   | D NUMBER OF REFERRING  3 OR 4 TO ITEM 24E BY LIN  D. SERVICES, OR SUPPLIES INJURIES INTERPRETATION OF THE PROPERTY OF THE PROP | E DIAGNOSIS CODE  T ASSIGNMENT? claims see back; | S 16 DATES PATIENT FROM MM D 18 HOSPITALIZATION DE PROM D 20 OUTSIDE LAB?  YES 22 MEDICAID RESU CODE 23 PRIOR AUTHORIC  5 CHARGES  80 33  | NO BMISSR ZATION 1 1 1 1 1 1 2 2     | ES RELA ON ORIGINAL NUMBE  H S EPSD TO Family Family 9 AMOU | S CH.    | O CORP                      | RESEASO BALA | K<br>RVED FOR |

| PLEASE<br>DO NOT<br>STAPLE<br>IN THIS   | 0  | Private                          | l from prev<br>Provider<br>ation only   | ious               | cl                | aim.               | 1           |   |
|---|--|----------------------------------|---|--------------------|-------------------|--------------------|-------------|---|
| AREA  |  | previous                         | llers only<br>page<br>INSURANCE   |                    |                   |                    |             | from                                    |
| 1 MEDICARE MEDICAID CHAMPUS CHAM (Medicare #) (Medicaid #) (Sponsor's SSN) (VA  | MPVA GROUP HEALTH PLAN File #1 (SSN or ID)                           | FECA OT                          | HER 1a INSURED'S I.D  |                    | ₹                 |                    |             | R PROGRAM IN                            |
| 2 PATIENT'S NAME (Last Name, First Name, Middle Initial)  | 3 PATIENT'S BIRTH DATE   |                                  | 4 INSURED'S NAM   |                    |                   |                    | ne. Mia     | die Initial)                            |
| Recipient, Joe 5 PATIENT'S ADDRESS (No., Street) 111 Paginiant Street   | 6. PATIENT RELATIONSHIP  | TO INSURED                       | 7 INSURED'S ADD   | RESS (N            | . Stree           | et:                |             |   |
| 111 Recipient Street  | Self Spouse Cr   | oild Other                       | CITY  |                    |                   |                    |             | STA                                     |
| Recipient Town I ZIP CODE TELEPHONE (Include Area Code)   | NC Single Married  | Other                            |   |                    |                   |                    |             |   |
| 12345 (999) 999_9999  | Employed — Full-Time<br>Student                                      | Student                          | ZIP CODE  |                    | İ                 | (                  | )           | CLUDE AREA C                            |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)   | 10. IS PATIENT'S CONDITIO  | N RELATED TO                     | 11. INSURED'S PO  | ICY GRO            | UP OR             | FECA               | NUMBI       | R                                       |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER   | a. EMPLOYMENT? (CURRENT)   | T OR PREVIOUS)                   | a. INSURED'S DATE   | OF BIRT            | н                 |                    |             | SEX                                     |
| b. OTHER INSURED'S DATE OF BIRTH SEX  | b. AUTO ACCIDENT?  | PLACE (Star                      | te) b. EMPLOYER'S NA  | ME OR S            | CHOOL             |                    | М           | F                                       |
| c. EMPLOYER'S NAME OR SCHOOL NAME   | c. OTHER ACCIDENT?   | NO                               | c. INSURANCE PLA  | NAME (             | R PRO             | OGRAM              | NAME        |   |
| d. INSURANCE PLAN NAME OR PROGRAM NAME  | YES 10d. RESERVED FOR LOCAL  | NO USE                           |   |                    |                   |                    |             | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
| READ BACK OF FORM BEFORE COMPLET  |  |                                  | d IS THERE ANOTH  | ER HEAL<br>NO      |                   |                    |             | complete item 9                         |
| 17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE  19 RESERVED FOR LOCAL USE  21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEM:  1  | 3. L   | PHYSICIAN                        | \$ 16 DATES PATIENT FROM MM DI FRO | NO MISSION ATION N | ORIG              | TED TO             | CURR        | ENT SERVICES<br>DD YY                   |
| 11 01 03 11 01 03 11 9070   | 0  |                                  | 0 00  | 1                  | Ì                 |                    |             |   |
| 11 01 03 11 01 03 11 9070   | 7  |                                  | 0 00  | 1                  |                   |                    |             |   |
|   |  |                                  |   |                    | $\top$            | $\exists$          |             | -                                       |
| FEDERAL TAX I.D. NUMBER SSN EIN 26 PATIENT'S  | (For govt  | ASSIGNMENT?<br>claims, see back) | 28. TOTAL CHARGE  | - 1                | AMOU              | NT PAIL            | D           | 30. BALANCE D                           |
| SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREEDINTALS (Lordiny that the statements on the reverse apply to this bill and are made a part thereof.)  Signature on File | YES<br>ADDRESS OF FACILITY WHERE S<br>(If other than home or office) | NO<br>ERVICES WERE               | 111   | Jar<br>Pro         | e F<br>vic<br>r T | rov<br>ler<br>'owr | /ide<br>Str | er<br>reet<br>IC 1234                   |

| PLEASE<br>DO NOT<br>STAPLE<br>IN THIS<br>AREA  |   |             |                     |           |   | 0:                               | Privat<br>Period<br>Vision<br>One Im    | ic S<br>and            | cre<br>he      | enim<br>arim          | ng                 |             |   |
|--|---|-------------|---------------------|-----------|---|----------------------------------|---|------------------------|----------------|-----------------------|--------------------|-------------|---|
| PICA   |   |             |                     |           |   | HEALTH I                         | Paper                                   | bill                   | ers            | on]                   | y/s                | pli         | t claim                                     |
| 1  | IICAID                                  | CHAMP       |                     | AMPVA     | GROUP<br>HEALTH PLAN                                  | FECA OTH<br>BLK LUNG             | HER 1a INSU                             | RED'S I.C              | NUME           | BEP                   | UHI                |             | PICA<br>R PROGRAM IN F                      |
| 2. PATIENT'S NAME (Last  | licaid #)<br>Name, First N              |             |                     | 'A File # | וטו וט אופפן  | (SSN: (ID                        |   | 3333                   | 333            | 3X                    | C b                |             | die Initiali                                |
| Recipient,   | Jane                                    |             |                     |           | 3 PATIENT'S BIRTH DATE MM DD YY 1998                  | M SEX                            |   |                        |                | - maine               | 1 1131 114         | me, wiig    | ure minari                                  |
| 111 Recipi   | ent St                                  | reet        | :                   |           | 6 PATIENT RELATIONSHIP Self Spouse Ch                 |                                  | 7 INSUR                                 | ED'S ADI               | RESS           | (No , Stri            | eet)               |             |   |
| CITY   | <b>n</b>                                |             | i                   |           | 8. PATIENT STATUS                                     |                                  | CITY                                    |                        |                |                       |                    |             | STAT  |
| Recipient '  |   | HONE (in    | nclude Area Code)   | NC        | Single Married  | Other                            | ZIP CODE                                |                        |                | Ţ                     | FLEPH              | ONE III     | ICLUDE AREA CO                              |
| 12345<br>9 OTHER INSURED'S NAM   | ( g                                     | 99 9        | 99_9999             | ,         | Employed Full-Time<br>Student                         | Student                          | -                                       |                        |                |                       | (                  | )           |   |
| o one made by the  | c (cast warne                           | r, FIISTINA | me, Middle Initial) |           | 10. IS PATIENT'S CONDITIO                             | ON RELATED TO                    | 11. INSUF                               | ED'S PO                | LICY GI        | ROUP O                | R FECA             | NUMB        | ER  |
| a. OTHER INSURED'S POL   |   | JP NUMB     | ER                  |           |   | NO                               |   | D'S DAT                | E OF B         | RTH<br>/Y             |                    | м           | SEX F                                       |
| b. OTHER INSURED'S DAT   |   | и           | F                   |           | YES   | PLACE (State                     | e) b. EMPLO                             | YER'S NA               | ME OR          | SCHOO                 | L NAM              | E           |   |
| c. EMPLOYER'S NAME OR  | SCHOOL NAM                              | ИE          |                     | 7         | OTHER ACCIDENT?                                       |                                  | c INSURA                                | NCE PLA                | N NAMI         | OR PR                 | OGRAN              | A NAME      |   |
| d. INSURANCE PLAN NAME   | OR PROGRA                               | AM NAME     |                     | 1         | 0d RESERVED FOR LOCAL                                 | USE                              | d. IS THER                              | E ANOTH                | ER HE          | ALTH BE               | NEFIT              | PLAN?       |   |
| RE 12 PATIENTS OR AUTHOR   | AD BACK OF                              | FORM E      | SEFORE COMPLE       | ETING 8   | SIGNING THIS FORM.<br>ease of any medical or other in |                                  | 13 INSUBI                               |                        | NO             | If ye                 | s. retur           | to and      | complete item 9 a                           |
| 19. RESERVED FOR LOCAL 21. DIAGNOSIS OR NATURE 1. L. V20. 2  |   | וטנאו אס    | RY (RELATE ITE      |           |   |                                  | 20. OUTSID<br>YE.<br>22. MEDICA<br>CODE | E LAB?<br>S<br>ID RESU | NO<br>BMISSI   | ORI                   | \$ CH              | ARGES       |   |
| 2  |   |             |                     | 4 1       |   |                                  | 23 PRIOR A                              | UTHORI                 | ZATION         | NUMBE                 | R                  |             |   |
| DATE(S) OF SERV  | ICE <sub>TO</sub>                       | Place<br>of | C<br>Type PROCE     | DURES     | D<br>SERVICES, OR SUPPLIES                            | DIAGNOSIS                        | F                                       |                        | G<br>DAYS      | H<br>EPSD1            |                    | J           | RESERVED FO                                 |
| MM DD YY MM  |   | Y Servici   | Service CPT/H       | CPCS      | nusual Circumstances) MODIFIER                        | CODE                             | S CHAR                                  | GES                    | UNITS          | Family<br>Plan        | EMG                | сов         | LOCAL USE                                   |
|  | 01 03                                   |             | 1                   | 93        | EP  |                                  | 80                                      | 33                     | 1              | _                     | _                  | <u> </u>    |   |
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| 11 01 03 11  | 01 03                                   | 11          | 9255                | 52        | EP  |                                  | 0                                       | 00                     | 1              |                       |                    |             |   |
| 11 01 03 11  | 01,03                                   | 11          | 9047                | 1         | EP  |                                  | 13                                      | 71                     | 1              |                       |                    |             |   |
| 11 01 03 11  | 01 03                                   | 11          | 9071                | 3         |   |                                  | 0                                       | 00                     | 1              |                       |                    |             |   |
|  |   |             |                     |           | Ι Τ   |                                  |   |                        |                |                       |                    |             |   |
| 5. FEDERAL TAX I.D. NUMBE  | 9 SSN                                   | EIN         | 26 PATIENT'S        | S ACCO    | (For govt.  | ASSIGNMENT?<br>claims, see back) | 28. TOTAL CH                            | IARGE                  | 2              | 9 AMOL                | JNT PA             | ID          | 30. BALANCE DU                              |
| 31. SIGNATURE OF PHYSICIA INCLUDING DEGREES OR (I certify that the statements apply to this bill and are mad Signature on SIGNATURE) | CREDENTIAL ON the reverse a part thereo | .S<br>of.)  | 32 NAME AND RENDERE | D ADDR    | YES ESS OF FACILITY WHERE S er than home or office)   | NO<br>SERVICES WERE              | S 33. PHYSICIA & PHONE                  | Dr.<br>111<br>Pro      | Jc<br>Pr<br>Pr | e P:<br>ovid<br>er, ' | rov:<br>der<br>Tow | ider<br>Str | \$ 94 0<br>ESS ZIP CODE<br>Ceet<br>IC 12345 |
|  | NCIL ON MEI                             |             |                     |           |   |                                  | OMB-0938-00                             |                        |                |                       |                    |             |   |

| PLEASE  | ı            |   |               |            |                    |   | С   | ontinued f  | rom        | pre           | evic       | ous                        | claim                 |
|---|--------------|---|---------------|------------|--------------------|---|---|---|------------|---------------|------------|----------------------------|-----------------------|
| DO NOT<br>STAPLE  | į            |   |               |            |                    |   | ٥   | Private Pr  | ovi        | der           |            |                            |                       |
| IN THIS<br>AREA   | i            |   |               |            |                    |   | o   | Immunizati  | ons        | on]           | Ly         |                            |                       |
|   |              |   |               |            |                    |   |   |   |            |               |            |                            |                       |
| PICA<br>1 MEDICARE  | MEDICA       | iD                                      | CHAMP         | US         | CHAMPV             | /A GROUP                                |   | NSURANCE<br>HER 1a. INSURED'S I.C   |            |               | OR         |                            | PI                    |
| (Medicare #)  | (Medican     | a #) (                                  | Sponso        | r's SSN)   | - (VA File         | #) HEALTH PLAN<br>(SSN or ID)           | BLK LUNG (ID                                | 33333   |            |               |            | rFOI                       | A PROGRAM IN          |
| Recipie   |              |   | ne. Miac      | die Initia | 1)                 | 3 PATIENT'S BIRTH D. MM DD YY 08 01 199 | 98 <sub>M</sub> SEX                         | 4. INSURED'S NAI  |            |               | First Na   | me, Mia                    | dle Initiai)          |
| 5. PATIENT'S ADD  | RESS (No., S | Street)                                 |               |            |                    | 6. PATIENT RELATION                     |   | 7 INSURED'S ADD   | DRESS      | (No , Stre    | eet:       |                            |                       |
| 111 Rec   | ıpıen        | t St                                    | reet          |            | STATE              | Self Spouse  8. PATIENT STATUS          | Child Other                                 | CITY  |            |               |            |                            | st                    |
| Recipie   | nt To        | wn                                      |               |            | NC                 | 1                                       | ried Other                                  |   | _          |               |            |                            | STA                   |
| 12345   |              |   |               |            | rea Code)<br>.9999 |   | ime Part-Time                               | ZIP CODE  |            | Т             | ELEPHI     | ONE (IN                    | ICLUDE AREA (         |
| 9 OTHER INSURED   | S NAME (L    | ast Name.                               | First Nai     | me, Midi   | ole initial)       | 10. IS PATIENT'S CONI                   |   | 11 INSURED'S PO   | LICY G     | ROUP O        | A FECA     | NUMBE                      | ER                    |
| a. OTHER INSURED  | 'S POLICY    | OR GROUI                                | NUMB          | ER         |                    | a. EMPLOYMENT? (CUR                     |   | a. INSURED'S DAT  | E OF B     | RTH           |            |                            | 657                   |
| b. OTHER INSURED  | 'S DATE OF   | DIDT:                                   |               |            |                    | YES                                     | NO  |   |            |               |            | м :-                       | SEX<br>F              |
| MM DD YY  |              | ВІЯТН<br>М                              |               | EX<br>F    | ,                  | b. AUTO ACCIDENT?  YES                  | PLACE (Stat                                 | b. EMPLOYER'S NA  | AME OF     | SCHOO         | L NAME     | E                          |                       |
| c. EMPLOYER'S NAI   | ME OR SCH    | OOL NAMI                                |               |            |                    | c. OTHER ACCIDENT?                      |   | c. INSURANCE PLA  | N NAM      | E OR PR       | OGRAN      | M NAME                     |                       |
| d. INSURANCE PLAN   | NAME OR      | PROGRAM                                 | A NAME        |            |                    | YES<br>10d. RESERVED FOR LO             | NO<br>DCAL USE                              | d. IS THERE ANOTH   | 1ER HE     | ALTH RE       | NEFIT      | PLANO                      |                       |
|   | DEAC         | BACKOS                                  | OB!           | ieco       | COMO:              | & SIGNING THIS FORM.                    |   |   | NO.        | If ye         | s. return  | n to and                   | complete item 9       |
| 17. NAME OF REFER  19. RESERVED FOR  21. DIAGNOSIS OR N         | RING PHYS    | i T                                     | ОТНЕЯ         | SOURC      | DE 17a.            | I.D. NUMBER OF REFERE                   |   | S 16 DATES PATIENT FROM D 18. HOSPITALIZATIC FROM D 20. OUTSIDE LAB?  22. MEDICAID RESU | DN DAT     | ES RELA       | T S CH.    | O CURR<br>MM<br>O<br>ARGES | ENT SERVICES<br>DD YY |
| ₁ <u></u>   |              |   |               |            |                    |   |   | CODE CODE   | DMISSI     | ORI           | GINAL F    | REF. NO                    | <b>)</b> .            |
| 2   |              |   |               |            | 4.                 |   |   | 23. PRIOR AUTHORI   | ZATION     | NUMBE         | R          | -                          |                       |
| 24 A<br>DATE(S) O<br>From                                       | F SERVICE    |   | B<br>Place    | С          | [                  | D<br>ES. SERVICES, OR SUPPL             | E E   | F   | G          | Н             | 1          | J                          | К                     |
| MM DD YY  |              |   | of<br>Service | 1 of       | (Explain           | Unusual Circumstances                   | DIAGNOSIS<br>CODE                           | \$ CHARGES  | OR<br>UNIT |               | EMG        | сов                        | RESERVED<br>LOCAL U   |
| 11 01 03  | 11 (         | 01_03                                   | 11            |            | 90471              | EP                                      |   | 0.00  | 1          |               |            |                            |                       |
| 11 01 03  | 11 (         | 01 03                                   | 11            |            | 90472              | EP                                      |   | 13 71   | 1          |               |            |                            |                       |
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|   |              |   | <u> </u>      | -          | 30,07              |   |   | 0.00  | <u> </u>   | _             |            |                            |                       |
|   |              |   |               |            |                    |   |   |   |            |               |            |                            |                       |
|   |              |   |               |            |                    | 1                                       |   |   |            |               |            |                            |                       |
| FEDERAL TAX I.D   | NUMBER       | SSN                                     | EIN           | 26. F      | PATIENT'S ACC      | COUNT NO. 27, ACC                       | CEPT ASSIGNMENT?<br>govf. claims, see back) | 28 TOTAL CHARGE   | 1          | 29. AMOL      | JNT PAI    | ID                         | 30. BALANCE [         |
| SIGNATURE OF PH<br>INCLUDING DEGRE<br>(I certify that the state | ES OR CRE    | EDENTIALS<br>ne reverse<br>part thereof | ;             | :          | RENDERED (II       |   | ES NO                                       | 111   | JC<br>Pr   | e Pr          | ovi<br>Jer | ider<br>Str                |                       |
| apply to this bill and a  | On F         | םווי                                    |               |            |                    |   |   | Pro   | v I ()     | <b>ਦ</b> ਾ 'I | LOWE:      | ı. IN                      | C 1234                |
| Signature GNED  (APPROVED BY AN                                 |              | DATE                                    |               | _          |                    |   |   | PIN# 00000  |            |               |            |                            | 0000                  |

| DO NOT<br>STAPLE<br>IN THIS<br>AREA                               |                          |                   |               |   |                               |                             |                                    | °Private P<br>°Interperi   | rovi<br>odio     | ider<br>Sc      | ree             | ning       | 9            |         |
|---|--------------------------|-------------------|---------------|---|-------------------------------|-----------------------------|------------------------------------|--|------------------|-----------------|-----------------|------------|--------------|---------|
| PICA  |                          |                   |               |   |                               |                             | HEALTH                             | INSURANCE  | CI A             | IM F            | ORI             | VI         |              | PICA    |
| MEDICARE (Medicare #)   | MEDICAID<br>(Medicaid #) | CHAMP<br>(Sponsor |               | CHAMPV<br>(VA File                      | A GRO                         | DUP<br>LTH PLAN<br>N or ID) | FECA O<br>BLK LUNG<br>(SSN)        |  | D NUME 2222      | BER             |                 |            | R PROGRA     |         |
| 1   | ent, Jane                | ame, Midd         | le Initial    | )                                       | To or                         |                             |                                    |  |                  |                 |                 | ime. Mide  | die Initial. |         |
| 5. PATIENT'S ADD  | RESS (No., Street)       |                   |               | *************************************** | 6. PATIENT                    | RELATIONSHI                 | P TO INSURED                       | 7 INSURED'S AD   | DRESS            | iNo . Stri      | eet:            |            |              |         |
| CITY  | cipient S                | ree               | =             | STATE                                   | 8 PATIENT                     | Spouse (                    | Child Otner                        | CITY   |                  |                 |                 |            |              | STATE   |
| Recipie<br>ZIP CODE   | ent Town                 | HONE (In          | clude Ar      | NC ea Code                              | Single                        | Marnec                      | Other                              | ZIP CODE   |                  |                 |                 |            |              |         |
| 12345   |                          | 99) 99            | 9-9           | 999                                     | 1                             | Student                     | Part-Time<br>Student               | -  |                  |                 | (               | )          | CLUDE AR     | EA CO   |
|   |                          |                   |               | ile initiali                            | 10. IS PATIE                  | NT'S CONDIT                 | ON RELATED TO                      | 11 INSURED'S PO  | DLICY GI         | POUP O          | R FECA          | NUMBE      | R            |         |
| a. OTHER INSURED  | S POLICY OR GROU         | JP NUMBE          | ĒR .          |   | a. EMPLOYM                    |                             | NT OR PREVIOUS                     | a INSURED'S DA   | TE OF B          | RTH<br>YY       |                 |            | SEX          |         |
| b. OTHER INSURED<br>MM DD Y                                       | ·                        | , — SI            | X F           |   | b. AUTO ACC                   | IDENT?                      | PLACE (Sta                         | b. EMPLOYER'S N  | AME OR           | SCHOO           |                 | м          |              | F       |
| c. EMPLOYER'S NA  | ME OR SCHOOL NAM         |                   |               |   | c OTHER AC                    |                             | NO                                 | c. INSURANCE PL  | AN NAMI          | OR PR           | OGRAN           | 4 NAME     |              |         |
| d. INSURANCE PLA  | NAME OR PROGRA           | M NAME            |               |   |                               | YES<br>ED FOR LOCA          | NO<br>L USE                        | d IS THERE ANOT  |                  |                 |                 |            |              |         |
|   | READ BACK OF             | FORM B            | EEODE         | COMPLETING                              | • CICHELO TI                  |                             |                                    | YES  | NO               | If ye           | s. return       | n to and o | complete ite | em 9 a- |
| 17. NAME OF REFER  19. RESERVED FOR  21. DIAGNOSIS OR N  1 LV70.3 | RING PHYSICIAN OF        | OTHERS            | SOURCI        | ATE ITEMS 1,2                           | .D. NUMBER C                  | OF REFERRING                |                                    | IS 16 DATES PATIEN FROM 18 HOSPITALIZATI FROM MM C 20 OUTSIDE LAB?  22 MEDICAID RESUCCODE  23 PRIOR AUTHOR | ON DATE DD Y  NO | ON ORK          | TED TO<br>S CHA |            | DD :         |         |
| 24 A<br>DATE(S) O<br>From   | F SERVICE_               | B                 | C<br>Type     | PROCEDURE                               | D<br>S. SERVICES.             | OR SUPPLIES                 | E                                  | F  | G                | H               |                 | J          | K            |         |
| MM DD YY<br>11 01 03  | 11 01 0:                 | 0.0171.00         | of<br>Service | (Explain<br>CPT/HCPCS                   | Unusual Circum                | netanneel                   | DIAGNOSIS<br>CODE                  | \$ CHARGES   | UNITS            | Family          | EMG             | сов        | HESERV       | ED FO   |
| 11 01 03  | 11 01 0.                 | 7 11              | _             | 99393                                   | EP                            |                             |                                    | 80 33  | 1                |                 |                 |            |              |         |
|   |                          | +                 |               |   |                               |                             |                                    |  | 1_               |                 |                 |            |              |         |
| -   |                          |                   |               |   |                               |                             |                                    |  |                  |                 |                 |            | -            |         |
|   |                          |                   |               |   |                               |                             |                                    |  |                  |                 |                 |            |              |         |
|   |                          |                   |               |   | 1                             |                             |                                    |  |                  |                 |                 |            |              |         |
|   |                          |                   |               |   | 1                             |                             |                                    |  |                  |                 | $\dashv$        |            |              |         |
| 5. FEDERAL TAX I.D.   |                          | EIN               | 26 P/         | ATIENT'S ACC                            | DUNT NO.                      | 27 ACCEP<br>(For govi       | T ASSIGNMENT?<br>claims, see back) | 28 TOTAL CHARGE  | 25               | AMOU            | NT PAR          | D 3        | 30. BALANO   | CE DUE  |
| (I certify that the state   |                          | R<br>S            | 32. NA        | AME AND ADDI                            | RESS OF FACI<br>her than home | YES                         | NO<br>SERVICES WERE                |  | PLIER'S          | BILLING<br>De P | rov<br>der      | ADDRE      | s E          | 30: 3   |

| PLEASE DO NOT STAPLE IN THIS AREA   |  | o   | Private Pr<br>Interperio<br>Immunizati | dic So<br>ons                    | creei      |             | ī               |
|---|--|---|--|----------------------------------|------------|-------------|-----------------|
| PICA  MEDICARE MEDICAID CHAMPUS   | CHAMPVA GROUP  |   | INSURANCE                              |                                  | FOR        |             | £               |
| (Medicare #) (Medicaid #) (Sponsor's SSN)  2 PATIENT'S NAME (Last Name, First Name, Middle initial) | ···· (VA File #) ···· HEALTH PLAN  | BLK LUNG<br>(SSN: //                        |  | 333333                           |            | FOI         | R PROGRAM I     |
| Recipient, Jane   | 02 07 19   | 99 м — SEX                                  | 4 INSURED'S NAM                        | ∕E⊣Last Nam                      | e First Na | ame. Mid    | die mitiaii     |
| 5. PATIENT'S ADDRESS (No.: Street)  | 6 PATIENT RELATION Self Spouse   | ISHIP TO INSURED                            | 7 INSURED'S ADD                        | RESS INc. S                      | treet:     |             |                 |
| 111 Recipient Street  | STATE 8. PATIENT STATUS  | Office Other                                | CITY                                   |                                  |            | •           | ST              |
| Recipient Town ZIP CODE TELEPHONE (Include Area   |  | rned Other                                  | ZIP CODE                               |                                  | TELEBR     | ON 5 141    | ISLUME AREA     |
| 12345 ( 999 999–9) 9 OTHER INSURED'S NAME (Last Name, First Name, Middle                            | 999 Employed - Full-<br>Stud   | Time - Part-Time<br>ent Student             |  |                                  | (          | )           | ICLUDE AREA     |
|   | initial) 10. IS PATIENT'S CON  | DITION RELATED TO                           | 11. INSURED'S PO                       | LICY GROUP                       | OR FEC     | A NUMBE     | ER              |
| a OTHER INSURED'S POLICY OR GROUP NUMBER  | a. EMPLOYMENT? (CU   | RRENT OR PREVIOUS:                          | a. INSURED'S DATE                      | OF BIRTH                         |            |             | SEX             |
| b OTHER INSURED'S DATE OF BIRTH SEX   | b. AUTO ACCIDENT?  | PLACE (Sta                                  | te) b. EMPLOYER'S NA                   | ME OR SCH                        | OOL NAM    | M<br>IE     | F               |
| C. EMPLOYER'S NAME OR SCHOOL NAME   | c. OTHER ACCIDENT?   | NO  | c INSURANCE PLA                        | N NAME OR I                      | PROGRA     | M NIAME     |                 |
| d INSURANCE PLAN NAME OR PROGRAM NAME   | YES  | NO NO                                       |  |                                  |            |             |                 |
|   |  |   | d IS THERE ANOTH                       |                                  |            |             | complete item   |
|   | DMPLETING & SIGNING THIS FORM, uthorize the release of any medical or of |   | 13. INSURED'S OR A payment of medic    | UTHORIZED                        | PERSON     | I'S SIGN    | ATURE Lauth     |
| to process this claim. I also request payment of government be below.                               | nefits either to myself or to the party wh                               | o accepts assignment                        | services describe                      | d below                          | me under   | signed pr   | nysician or sup |
| 14 DATE OF CURRENT A ILLNESS (First symptom) OR   | DATE   |   | SIGNED                                 |                                  |            |             |                 |
| 14 DATE OF CURRENT (ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)                  | 15. IF PATIENT HAS HAD SAN<br>GIVE FIRST DATE MM                         | DD YY<br>00 0000                            | S. 16. DATES PATIENT<br>MM DI<br>FROM  | UNABLE TO                        | WORK IN    | CURRE<br>MM | NT OCCUPAT      |
| 17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE  | 17a. I.D. NUMBER OF REFER  | RING PHYSICIAN                              | 18. HOSPITALIZATIO                     | N DATES RE                       | LATED TO   | O CURRI     | ENT SERVICE     |
| 19. RESERVED FOR LOCAL USE  |  | <del></del>                                 | 20. OUTSIDE LAB?                       |                                  | 1          | AAGES       |                 |
| 21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELAT  | FITEMS 123 OR 4 TO ITEM 245 BY   | / INE.                                      | YES                                    | NO                               |            |             |                 |
| V70.3   | 3  | - Lance                                     | 22. MEDICAID RESUL<br>CODE             | MISSION O                        | RIGINAL    | REF. NO     | ).              |
| 2   |  |   | 23. PRIOR AUTHORIZ                     | ATION NUM                        | BER        |             |                 |
| 24 A B C  | D<br>ROCEDURES, SERVICES, OR SUPP.                                       | E   | F                                      | G H                              |            | J           | K               |
| MM DD YY MM DD YY Service Service (   | (Explain Unusual Circumstances) DPT/HCPCS   MODIFIER                     | DIAGNOSIS<br>CODE                           | S CHARGES                              | DAYS EPS<br>OR Farr<br>UNITS PIA | IIY ENG    | сов         | RESERVED        |
| 12 05 03 12 05 03 11  | 99382   EP   |   | 80 33                                  | 1                                |            |             |                 |
| 2 05 03 12 05 03 11   | 90471   EP   |   | 13 71                                  | 1                                |            |             |                 |
| 12 05 00 10 05  | 90472   EP   | <u> </u>                                    | 13 71                                  |                                  |            | 1-1         |                 |
|   | LIE  | -   | 13 /1                                  | 1                                | +          | -           |                 |
| 12 05 03 12 05 03 11  | 90700  |   | 0 00                                   | 1                                |            |             |                 |
| 12 05 03 12 05 03 11  | 90713  |   | 0.00                                   | 1                                |            |             |                 |
| 12 05 03 12 05 03 11  | 90707  |   | 0 00                                   | 1                                |            |             |                 |
|   | IENT'S ACCOUNT NO 27 ACC   | DEPT ASSIGNMENT?<br>govf. claims, see back) | 28 TOTAL CHARGE                        | 29. AM                           | DUNT PA    | ID :        | 30 BALANCE      |
| SIGNATURE OF PHYSICIAN OR SUPPLIER 32. NAM     INCLUDING DEGREES OR CREDENTIALS REN                 | E AND ADDRESS OF FACILITY WHE  | ES NO<br>RE SERVICES WERE                   | s 107 7                                | PLIER'S BILLI                    | NG NAME    | E. ADDE     | s 107           |
| (I certify that the statements on the reverse apply to this bill and are made a part thereof.)      | DERED (if other than home or office)                                     |   | br.                                    | Joe 1                            | Prov.      | ider        |                 |
|   |  |   |  | Prov:<br>vider                   |            |             | eet<br>IC 1234  |
| Signature on File   |  |   |  |                                  |            |             |                 |
| Signature on File  GNED DATE 12/07/03  IAPPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88             |  |   | D OMB-0938-0008 FORM                   |                                  | GRP#       |             |                 |

| DO NOT<br>STAPLE<br>IN THIS<br>AREA  |  |   |   | c   | Private P<br>Immunizat  | rovid<br>ions   | er<br>onl  | У                                   |   |
|--|--|---|---|---|---|---|--|-------------------------------------|---|
| PICA   |  |   |   | HEALTH I  | NSURANCE  | CLAII   | M FC   | )RM                                 | P.C   |
| I .  | aid #) (Sponso   | r's SSN) (VA  | MEATTH OLAN   |   | HER 1a INSURED'S I  |   | 3  | _                                   | OR PROGRAM IN   |
| Recipient,   |  | dle Initial)  | 3 PATIENT'S BIRTH DAY<br>MM DD YY<br>09 06 200  | TE SEX  | 4. INSURED'S NA   | ME (Last N  | ame. Fir   | st Name. Mi                         | iddie initiai   |
| 5. PATIENT'S ADDRESS (No. 111 Recipie  | . Street   |   | 6 PATIENT RELATIONS   | HIP TO INSURED  | 7 INSURED'S AD  | DRESS (No   | Street   |                                     |   |
| CITY   |  | STA   | TE 8 PATIENT STATUS   | Child Other   | CITY  |   |  |                                     | STA   |
| Recipient To   |  | NO<br>nclude Area Code)   | Single Marrie   | ed Other  | ZIP CODE  |   | 1.75   |                                     |   |
| 12345<br>9. OTHER INSURED'S NAME   | (999) 99   | 99-9999<br>me Middle Initial  | Employed Full-Tin<br>Student  | f Student   |   |   |  | ( )                                 | INCLUDE AREA CO   |
| a OTHER INSURED'S POLICY   |  |   | 10. IS PATIENT'S CONDI  |   | 11 INSURED'S PO   | LICY GRO  | UP OR F  | FECA NUME                           | BEA   |
|  |  | ER  | a EMPLOYMENT? (CURR   | RENT OR PREVIOUS:   | a INSURED'S DAT   | E OF BIRT   | н  | м                                   | SEX   |
| b. OTHER INSURED'S DATE C  | DF BIRTH S   | EX F  | b AUTO ACCIDENT? YES  | PLACE (Stat   | e) b. EMPLOYER'S N  | AME OR SO   | HOOL   |                                     |   |
| c. EMPLOYER'S NAME OR SC   |  |   | c. OTHER ACCIDENT?  |   | c. INSURANCE PLA  | IN NAME C   | R PROC   | SRAM NAM                            | E   |
| d INSURANCE PLAN NAME OF   | R PROGRAM NAME   |   | YES<br>10d RESERVED FOR LOC   | NO<br>CAL USE   | d IS THERE ANOT   | HER HEAL  | H RENE   | FEIT DI ANIO                        |   |
| 12 PATIENT'S OR AUTHORIZE  | BACK OF FORM B   | EFORE COMPLET   | ING & SIGNING THIS FORM.  |   | YES 13 INSURED'S OR   | NO  | If yes.  | return to and                       | d complete item 9 a   |
|  |  |   |   |   |   |   |  |                                     | RENT SERVICES   |
| 19 RESERVED FOR LOCAL US 21 DIAGNOSIS OR NATURE OF   | _  | RY (RELATE ITEMS  | 5 1,2,3 OR 4 TO ITEM 24E BY LI  | INE)  | 20. OUTSIDE LAB? YES 22. MEDICAID RESU  | NO  | 5  | 5 CHARGES                           |   |
|  | _  |   | 3 L   | INE:  | 20. OUTSIDE LAB? YES 22. MÉDICAID RESU  | NO BMISSION   | ORIGIN   |                                     | <u> </u>  |
| 21 DIAGNOSIS OR NATURE OF 1 V04.0  | FILLNESS OR INJUR  |   |   | INE:  | 20. OUTSIDE LAB? YES  22. MÉDICAID RESU CODE  23. PRIOR AUTHORI   | NO BMISSION   | ORIGIN   | 5 CHARGES                           |   |
| 21 DIAGNOSIS OR NATURE OF  1   | B Place  | C<br>Type PROCEDU   | 4 L D D D D D D D D D D D D D D D D D D D   | E<br>S DIAGNOSIS  | 20. OUTSIDE LAB?  YES  22. MÉDICAID RESU CODE  23. PRIOR AUTHORI  | MO BMISSION NL  | ORIGIN<br>MBER   | S CHARGES                           | O. K. RESERVED F.   |
| 21 DIAGNOSIS OR NATURE OF  LV04_0  2 L  24 A  FIGURATE(S) OF SERVICE  MM DD YY MM  | B B Place of of  | C<br>Type PROCEDU   | 3 L D D D D D D D D D D D D D D D D D D   | <b>↓</b>  | 20 OUTSIDE LAB?  YES  22 MEDICAID RESU CODE  23 PRIOR AUTHORI  F  S CHARGES   | NO BMISSION NU  | ORIGIN<br>MBER   | 5 CHARGES                           | O. K. RESERVED F.   |
| 21 DIAGNOSIS OR NATURE DE 1 L V04 0 0 2 L 2 L 2 A A DIAGNOSIS OF SERVICE MM DD YY MM 11 22 03 11 2   | B Place of DD YY Service   | C Type PROCEDU of (Expl Service CPT/HCP   | 3 L  DES SERVICES OR SUPPLIE an Unusual Circumstances) CS I MODIFIER T1 EP  | E<br>S DIAGNOSIS  | 20. OUTSIDE LAB?  YES  22. MÉDICAID RESU CODE  23. PRIOR AUTHORI  | BMISSION NU ZATION NU G DAYS E OR F UNITS   | ORIGIN<br>MBER   | S CHARGES                           | O. K. RESERVED F.   |
| 21 DIAGNOSIS OR NATURE OF L V04 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0  | ET DD YY SPRICE 22 03 11   | Type PROCEDU (Explose Service OFFMCP 9047   | 3 L   | E<br>S DIAGNOSIS  | 20 OUTSIDE LAB?  YES  22 MEDICAID RESUCCODE  23 PRIOR AUTHORI  F  S CHARGES  13 71  13 71   | DAYS E OR FUNITS  | ORIGIN<br>MBER   | S CHARGES                           | O. K. RESERVED F.   |
| 21 DIAGNOSIS OR NATURE OF L. V04.0  2 L  | ETO Place Of Solve 122 03 11 22 03 11  | C Type PROCEDU OF SANCE OF TAPE 9047 9047   | 3 L   | E<br>S DIAGNOSIS  | 20 OUTSIDE LAB?  YES  22 MEDICAID RESU CODE  23 PRIOR AUTHORI  F  S CHARGES  13 71  0 00  | NO BMISSION NL ZATION NL ZATION NL  G DAYS E OR UNITS  1 1  | ORIGIN<br>MBER   | S CHARGES                           | O. K. RESERVED F.   |
| 21 DIAGNOSIS OR NATURE OF L V04 L 0  2 L 24 A DIAGNOSIS OR NATURE OF SERVICE MM DO YY MM  11 22 03 11 2  11 22 03 11 2  11 22 03 11 2  | ETC. Place OF INJURE 22 03 11 22 03 11 22 03 11  | C Type PROCEDU (Expl Service) 9047 9047 9070 9071   | 3 L   | E<br>S DIAGNOSIS  | 20 OUTSIDE LAB?  YES  22 MEDICAID RESUCCODE  23 PRIOR AUTHORI  F  S CHARGES  13 71  13 71   | NO BMISSION NL ZATION NL ZATION NL  G DAYS E OR UNITS  1 1  | ORIGIN<br>MBER   | S CHARGES                           | O. K. RESERVED F.   |
| 21 DIAGNOSIS OR NATURE OF L V04 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0  | ETC. Place OF INJURE 22 03 11 22 03 11 22 03 11  | C Type PROCEDU OF SANCE OF TAPE 9047 9047   | 3 L   | E<br>S DIAGNOSIS  | 20 OUTSIDE LAB?  YES  22 MEDICAID RESU CODE  23 PRIOR AUTHORI  F  S CHARGES  13 71  0 00  | DAYS E OR FUNITS 1  | ORIGIN<br>MBER   | S CHARGES                           | 0.  |
| 21 DIAGNOSIS OR NATURE OF 1 L Y04 0 0 2 L 2 A A CONTROL OF SERVICE MM DD YY MM 11 22 03 11 2 11 22 03 11 2 11 22 03 11 2   | ETC. Place OF INJURE 22 03 11 22 03 11 22 03 11  | C Type PROCEDU (Expl Service) 9047 9047 9070 9071   | 3 L D D S OR SUPPLIE SERVICES OR SUPPLIE SERVICES OR SUPPLIE SERVICES OF SUPPLIES | S DIAGNOSIS CODE  | 20 OUTSIDE LAB?  YES  22 MEDICAID RESU CODE  23 PRIOR AUTHORI  F  S CHARGES  13 71  0 00  0 00  0 00  | DAYS E ON THE PROPERTY OF THE | ORIGIN MBER  | S CHARGES                           | N RESERVED FO LOCAL USE   |
| 21 DIAGNOSIS OR NATURE OF  L V04   | ETO PROPERTY SERVICES OR INJURE PROPERTY SERVICES OR INJUR | C Type PROCEDU (6 Expl Service 9047 9047 9071 9064  | 3 L   | S DIAGNOSIS CODE  PT ASSIGNMENT? (*Cams. see back)                    | 20 OUTSIDE LAB?  YES  22 MEDICAID RESU  23 PRIOR AUTHORI  5  \$ CHARGES  13 71  0 00  0 00  0 00  28 TOTAL CHARGE  \$ 27 4                                | BMISSION NL ZATION NL ZATION NL DAYS E OR UNITS 1 1 1 1 1 1 29 A  | ORIGINMBER H SSDT Tamily Francisco   | S CHARGES  NAL REF NI  L J  EMG COB | RESERVED F. LOCAL USE   |
| 21 DIAGNOSIS OR NATURE OF  L V04 0  2 L  24  | ETO Place OF INJURE PROPRIET SERVICE SERVICE OF INJURE PROPRIET SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE S | C Type PROCEDU (1) (Explication of Service PATIENTS A: 9047 9064 9064 9064 9064 9064 9064 9064 9064 | 3   | S DIAGNOSIS CODE  PT ASSIGNMENT? (*Cams. see back)                    | 20 OUTSIDE LAB?  YES  22 MEDICAID RESU  23 PRIOR AUTHORI  F  S CHARGES  13 71  0 00  0 00  0 00  28 TOTAL CHARGE  5 27 4  33 PHYSICIAN'S, SUPI  8 PHONE # | NO N  | ORIGIN MBER  | PAID  AME, ADDE                     | RESERVED FILOCAL USE  30. BALANCE DU \$ 27 TRESS, ZIP CODE VICIOR Street            |
| 21 DIAGNOSIS OR NATURE OF  L V04 D  2 L  24 A  From Telsi of Service  MM D0 YY MM  11 22 03 11 2  11 22 03 11 2  11 22 03 11 2  11 22 03 11 2  11 22 03 11 2  11 22 03 11 2  11 22 03 11 2 | ETO Place OD YY Service 22 03 11 22 03 11 22 03 11 22 03 11 22 03 11 22 03 11 22 03 11 22 03 11 22 03 11 22 03 11 22 03 11 22 03 11 22 03 11 22 03 11 22 03 11 22 03 11 22 03 11 23 03 11 24 03 11 25 05 05 05 05 05 05 05 05 05 05 05 05 05   | C Type PROCEDU (19 19 19 19 19 19 19 19 19 19 19 19 19 1  | 3 L POSS OF SACULTY WARES   | S DIAGNOSIS CODE  PT ASSIGNMENTO A Claims, see back, NO SERVICES WERE | 20 OUTSIDE LAB?  YES  22 MEDICAID RESU  23 PRIOR AUTHORI  F  S CHARGES  13 71  0 00  0 00  0 00  28 TOTAL CHARGE  5 27 4  33 PHYSICIAN'S, SUPI  8 PHONE # | NO N  | ORIGIN MABER  H 18551 PSST1 PS | PAID  AME. ADDP  PTOVICE TOWN 100   | A RESERVED F LOCAL USE  30 BALANCE DO S 27  RESS. ZIP CODE  VICTOR STREET  A, NC 12 |

| TELEPHONE (Include Area Coope)  Single Married Other  TELEPHONE (Include Area Coope)  (   | TELEPHONE (Include Area Coope)  Single Married Other  TELEPHONE (Include Area Coope)  (  | STATE   NC   NC   Sage   Married   Colher   Co  | First Nar<br>C  | CHAMPUS CHAMPVA (Sponsor's SSN) (VA File lame. Middle Initial) | GROUP FECA BLK LUNG (SSN or ID)  3 PATIENT'S BIRTH DATE  06 11 2002 M X  6 PATIENT RELATIONSHIP TO INSURE                  | 4 INSURED   | 22222<br>S NAME (La | BER<br>222X<br>st Name. | First Na  | (FO                      | PICA PROGRAM IN ITEM 1) odde Initial) |
|---|--|---|---|--|--|---|---------------------|-------------------------|-----------|--------------------------|---------------------------------------|
| READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.  PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary serious dain i also request payment of government benefits either to myself or to the party who accepts assignment of medical benefits to the undersigned physician or supplier for services described below.  Jan Signed  Date  Signed  Signed  Signed  Signed  Jan ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)  INJURY (Accident) OR PREGNANCY(LMP)  AME OF REFERRING PHYSICIAN OR OTHER SOURCE  17a I.D. NUMBER OF REFERRING PHYSICIAN  18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY TO MM DD YY TO MM DD YY TO MM DD YY TO   | READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.  PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary serious distributions and complete item 9 and.  13 INSURED SOR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary serious described below.  13 INSURED SOR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary serious described below.  14 INSURED SOR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary serious described below.  15 INSURED SOR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  26 INSURED SOR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  26 INSURED SOR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  26 INSURED SOR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  27 INSURED SOR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  28 INSURED SOR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  28 INSURED SOR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  29 INSURED SOR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  29 INSURED SOR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described | READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.  PATIENTS OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary payment of medical benefits to the undersigned physician or supplier for services described below.  ISINUED  DATE  SIGNED  ALLINESS (FYRI symptom) OR MINUEY (Accident) OR PREGNANCYLIMP)  AME OF CURRENT PREGNANCYLIMP)  AME OF REFERRING PHYSICIAN OR OTHER SOURCE  17a I.D. NUMBER OF REFERRING PHYSICIAN  BESERVED FOR LOCAL USE  20 OUTSIDE LAB?  SOME PROBLEM ON TO MINUEY (RELATE ITEMS 1.2.3 OR 4 TO ITEM 24E BY LINE)  ADD BY MINUE OF SERVICE, PROCEDURES. SERVICES, OR SUPPLIES  FROM  ADD BY MINUE OF SERVICE, PROCEDURES. SERVICES, OR SUPPLIES  CODE  SCHARGES  AT 1 1 4 03 11 14 03 11 90472 EP  114 03 11 14 03 11 90472 EP  137 17 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1  | 2345 (99  | PHONE (Include Area Code)                                      | Single Married Oth  Employed — Full-Time — Part-Ti Student Studen  | ZIP CODE  |                     |                         | TELEPH    | ONE (IN                  | . 1                                   |
| PATIENTS OR AUTHORIZED PERSONS SIGNATURE I authorize the release of any medical or other information necessary below.  PATIENTS OR AUTHORIZED PERSONS SIGNATURE I authorize the release of any medical or other information necessary below.  DATE  DATE  DATE  DATE  SIGNED  TO  MM DD YY  TO  DATE  DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)  DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)  A B C D  PATIENT SARAD SAME OR SIMILAR ILLNESS  16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY  TO  MM DD YY  TO  TO  DATE  22. MEDICALD RESUBMISSION  ORIGINAL REF. NO.  23. PRIOR AUTHORIZATION NUMBER  PREDICALD RESUBMISSION  ORIGINAL REF. NO.  23. PRIOR AUTHORIZATION NUMBER  | PATIENTS OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim i also request payment of government benefits either to myself or to the party who accepts assignment.  DATE  DATE  DATE  SIGNED  DATE  SIGNED  DATE  SIGNED  DATE  SIGNED  SIGNED  DATE  SIGNED  A  ILLNESS (First symptom) OR RIVERY (Accident) OR PREGNANCY(LMP)  NAME OF REFERRING PHYSICIAN OR OTHER SOURCE  17a I.D. NUMBER OF REFERRING PHYSICIAN  TO  MM DD YY  FROM  DD YY  TO  TO  TO  TO  TO  TO  TO  TO  TO  | PATIENTS OR AUTHORIZED PERSON'S SIGNATURE 1 authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. Signature authorized person's Signature authorized person's Signature authorized the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. Signature authorized the release of any medical or other party who accepts assignment. Signature authorized benefits to the undersigned physician or supplier for services described below.    Patient   Date   Date | OTHER INSURED'S POLICY OR GROUP OTHER INSURED'S DATE OF BIRTH MM DD YY  | SEX  | 10 IS PATIENT'S CONDITION RELATED  a EMPLOYMENT? (CURRENT OR PREV  YES NO b AUTO ACCIDENT? PLACE  YES NO c OTHER ACCIDENT? | ITO 11. INSURED: IOUS) a INSURED: MM E (State) b. EMPLOYER                    | DATE OF B           | RTH<br>YY               | DL NAME   | м                        | SEX F                                 |
| DATE OF CURRENT ILLNESS (First symptom) OR MM DD YY PRECNANCY (LMP)  NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 17a I.D. NUMBER OF REFERRING PHYSICIAN  RESERVED FOR LOCAL USE  DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)  A B C D D SIGNED  15 IF PATIENT LINESS 16 DATES PRIENT OVER IN CURRENT OCCUPATION TO MM DD YY FROM TO MM DD YY TO MY DD | 14 DATE OF CURRENT   ILINESS (First symptom) OR   IS IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS   IS DATES P | 14_DATE OF CURRENT  | READ BACK OF 12 PATIENT'S OR AUTHORIZED PERSON to process this claim. I also request payme below.   | FORM BEFORE COMPLETING 8                                       | 10d. RESERVED FOR LOCAL USE  & SIGNING THIS FORM.  | YES  13. INSURED'S payment of   | NO<br>OR AUTHO      | RIZED P                 | s. return | to and                   | ATLIDE Lauthouse                      |
| A B C D E E C   | B C D E E C  | Particle   | MM DU YY NJURY (ACC)  7. NAME OF REFERRING PHYSICIAN OR O  9. RESERVED FOR LOCAL USE  1. DIAGNOSIS OR NATURE OF ILLNESS OF                | OR INJURY, (RELATE ITEMS 1.2.)                                 | PATIENT HAS HAD SAME OR SIMILAR IL VE FIRST DATE MM DD YY  D. NUMBER OF REFERRING PHYSICIAN  3 OR 4 TO ITEM 24E BY LINE;   | 16. DATES PAT FROM 18. HOSPITALIZ FROM 20. OUTSIDE LA YES 22. MEDICAID R CODE | B? NO ESUBMISSI     | ON ORI                  | \$ CHA    | CURR<br>MM<br>O<br>ARGES | ENT SERVICES<br>DD YY                 |
|   | 11 14 03 11 14 03 11 90471 EP 13 71 1 90472 EP 13 71 1   | 11 14 03 11 14 03 11  | DATE(S) OF SERVICE To   | Place of (Explain U<br>Y Service Service CPT/HCPCS             | i. SERVICES, OR SUPPLIES DIAGNO  | SIS \$ CHARGES  | DAYS<br>OR<br>UNITS | Family                  | EMG       | СОВ                      | K<br>RESERVED FOR<br>LOCAL USE        |
| 11 14 03 11 14 03 11 90713 0 00 1 55 55 55 56 56 56 56 56 56 56 56 56 56  | 25 PATIENT'S ACCOUNT NO 27 ACCEPT AS IGNMENT? [For ood claims see back]  YES NO \$ 74.02 \$ \$ 74.02   | INCLUDING DEGREES OR CREDENTIALS  32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE (I certify that the statements on the reverse apply to this bill and are made a part thereot.)  33 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE (I certify that the statements on the reverse apply to this bill and are made a part thereot.)  34 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE (I certify that the statements on the reverse apply to this bill and are made a part thereot.)  35 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE (I certify that the statements on the reverse apply to this bill and are made a part thereot.)  36 PHONE IN THE PROPERTY OF | 11 14 03 11 14 03 11 14 03 11 14 03 11 14 03 11 14 03 11 14 03 11 14 03 11 14 03 11 14 03 11 14 03 11 14 03 FEDERAL TAX I D NUMBER SSN EI | 11 90713 11 90707 EIN 26 PATIENT'S ACCOUNTS                    | (For govt, claims, see bayes NO  | 0 00  | ) 1<br>E   2        | \$                      | 1         |                          | 30. BALANCE DUE                       |

| PLEASE<br>DO NOT<br>STAPLE  |                                  |                        |                                       |                                 |   | •]  | FQHC/RHC<br>Periodic S                   | Scre                 | enin           | ıg      |            |                        |
|---|----------------------------------|------------------------|---------------------------------------|---------------------------------|---|---|--|----------------------|----------------|---------|------------|------------------------|
| IN THIS<br>AREA   |                                  |                        |                                       |                                 |   | 0,  | Vision and<br>Referral I                 | l he                 | arin           | g       |            |                        |
| PICA  |                                  |                        |                                       |                                 |   |   |  |                      |                |         |            |                        |
| 1. MEDICARE MI  |                                  | HAMPU                  | s                                     | CHAMPVA                         | GROUP<br>HEA) TH PLAN   | FECA OTH  | SURANCE<br>ER 1a. INSURED'S LE           | NUMB                 | ER             | HM      | (FOR       | PICA<br>PROGRAM IN ITE |
| (Medicare #) (M<br>2. PATIENT'S NAME (Las   |                                  | ponsor's<br>e, Middle  |                                       | (VA File A                      |   | BLK LUNG (ID)                                     | 4. INSURED'S NA                          |                      |                | st Nam  | e Midd     | lle Initial)           |
| Recipient,  |                                  |                        |                                       |                                 | 3. PATIENT'S BIRTH DAT<br>MM DD YY<br>07 01 1998<br>6. PATIENT RELATIONSH | M FX  |  |                      |                |         | 6, 171100  | ne mila)               |
| 111 Recipi  |                                  | eet                    |                                       |                                 | Self Spouse   |   | 7. INSURED'S ADD                         | RESS (               | No., Street    | 1)      |            |                        |
| Recipient   | Town                             |                        |                                       | STATE<br>NC                     | 8. PATIENT STATUS Single Marrie   | od Other  | CITY                                     |                      |                |         |            | STATE                  |
| ZIP CODE  | TELEPHO                          | `                      | lude Area Co                          | ode)                            | Employed Full-Tin   |   | ZIP CODE                                 |                      | TEI            | LEPHO   | NE (IN     | CLUDE AREA CODE        |
| 9. OTHER INSURED'S NA   | 1 ( 990<br>AME (Last Name, F     | irst Nam               | e, Middle Ini                         | ial)                            | Studen<br>10. IS PATIENT'S CONDI  | t Student   | 11. INSURED'S PC                         | LICY GF              | ROUP OR        | FECA N  | )<br>NUMBE | R                      |
| a. OTHER INSURED'S PO   | DLICY OR GROUP                   | NUMBE                  | R                                     |                                 | a. EMPLOYMENT? (CURF  | RENT OR PREVIOUS)                                 | a. INSURED'S DAT                         | E OF BII             | ЭТН            |         |            | SEX                    |
| b. OTHER INSURED'S DA   | ATE OF BIRTH                     | SE                     | · · · · · · · · · · · · · · · · · · · |                                 | YES   | NO PLACE (State                                   |  | 1                    |                |         | <b>/</b> 🔲 | F                      |
| MM DD YY  | м                                |                        | F                                     | 1                               | YES   | NO  | ) b. EMPLOYER'S N.                       | AME OR               | SCHOOL         | NAME    |            | -                      |
| c. EMPLOYER'S NAME O  | R SCHOOL NAME                    |                        |                                       |                                 | c. OTHER ACCIDENT?  | - NO  | c. INSURANCE PLA                         | N NAME               | OR PRO         | GRAM    | NAME       |                        |
| d. INSURANCE PLAN NAI   | ME OR PROGRAM                    | NAME                   |                                       |                                 | 10d. RESERVED FOR LOC   |   | d. IS THERE ANOT                         |                      | ALTH BEN       | EFIT P  | LAN?       |                        |
| 42 DATISTIC OR AUTO   | READ BACK OF F                   | ОЯМ ВЕ                 | FORE COM                              | PLETING .                       | & SIGNING THIS FORM.  |   | 13. INSURED'S OR                         | NO AUTHO             | RIZED PE       | RSON'S  | SSIGN      | complete item 9 a-d    |
| to process this claim. I below.  SIGNED   | also request payme               | nt of gove             | ernment ben                           | efits either to                 | elease of any medical or othe<br>o myself or to the party who             | accepts assignment                                | services describ                         | cal bene<br>od below | fits to the    | undersi | gned pl    | hysician or supplier f |
| 14. DATE OF CURRENT:  | ILLNESS (Firs                    | t sympto               | m) OR                                 | 15. IF                          | DATE PATIENT HAS HAD SAME IVE FIRST DATE MM                               | OR SIMILAR ILLNESS                                | SIGNED                                   | UNABL                | E TO WO        | RK IN ( | URRE       | NT OCCUPATION          |
| 17. NAME OF REFERRING   | ▼ PREGNANCY                      | (LMP)                  |                                       |                                 | D. NUMBER OF REFERRI  |   | FROM                                     |                      |                |         |            |                        |
| 19. RESERVED FOR LOC  | AI HSE                           |                        |                                       |                                 |   |   | 18. HOSPITALIZATI<br>MM (<br>FROM        | D   Y                | Y              |         |            | DD   YY                |
|   |                                  |                        |                                       |                                 |   |   | 20. OUTSIDE LAB?                         | NO                   | l              | \$ CHA  | RGES       | 1                      |
|   | RE OF ILLNESS O                  | R INJUR                | Y. (RELATE                            |                                 | 2,3 OR 4 TO ITEM 24E BY   | LINE)   | 22. MEDICAID RESU<br>CODE                | BMISSI               | ON ORIG        | INAL A  | EF. NO     | ).                     |
| 1. LV202  |                                  |                        |                                       | 3.                              | <u>-034</u> .0  |   | 23. PRIOR AUTHOR                         | IZATION              | NUMBER         | 3       |            |                        |
| 2. L 382_9<br>24. A   |                                  | В                      | С                                     |                                 | <u> </u>  | E   | F  | G                    | _ H ]          | 1       | J          | к                      |
| From DD YY M  | RVICE <sub>TO</sub>              | Place<br>of<br>Service | Type PR<br>of<br>Service C            | OCEDURE<br>(Explain<br>PT/HCPCS | S, SERVICES, OR SUPPLI<br>Unusual Circumstances)<br>  MODIFIER            | DIAGNOSIS<br>CODE                                 | \$ CHARGES                               | DAY<br>OR<br>UNIT    | Family         | EMG     | сов        | RESERVED FOR           |
| 10 11 03 ·  | 10 11 03                         | 11                     | 9                                     | 9383                            | EP  |   | 80 33                                    | 1                    | R              |         |            |                        |
| 10, 11   03   | 10 11 03                         | 11                     | 9                                     | 9172                            | EP  |   | 0 00                                     | 1                    |                |         |            |                        |
| 10, 11 ; 03   | 10 11 03                         | 11                     | 9                                     | 2552                            | EP  |   | 0 00                                     | 1                    |                |         |            |                        |
|   | 1 1                              |                        |                                       |                                 |   |   |  | 1-                   | +              |         |            |                        |
|   | 1 1                              |                        |                                       |                                 |   | <del></del>                                       |  | +                    | -              |         |            |                        |
|   | 1                                | -                      |                                       |                                 |   | -   | 1  |                      | +              | _       |            |                        |
| 5. FEDERAL TAX I.D. NUN   | ABER SSN                         | EIN                    | 1 26 PAT                              | ENT'S ACC                       | OUNT NO.  | ERT ACCIONATE                                     | an 70=                                   | L.,                  |                |         |            |                        |
|   |                                  | $\Box$                 |                                       |                                 | (For  | EPT ASSIGNMENT?<br>govt claims, see back)<br>S NO |  | 33                   | 29. AMOU<br>\$ | į       |            | s 80 3                 |
| <ol> <li>SIGNATURE OF PHYSII<br/>INCLUDING DEGREES<br/>(I certify that the stateme</li> </ol> | OR CREDENTIALS<br>on the reverse | S                      | 32. NAM                               | E AND ADD                       | DRESS OF FACILITY WHE other than home or office)                          | RE SERVICES WERE                                  | 33. PHYSICIAN'S, SU<br>& PHONE #         |                      | s BILLING      |         |            |                        |
| apply to this bill and are i  | made a part thereo               | L)                     |                                       |                                 |   |   | 1.                                       | 11 F                 | rovi           | der     | st         | reet                   |
| Signature o   |                                  | 11/1                   | 12/03                                 |                                 |   |   | PIN# 000000                              |                      |                |         |            | NC 12345               |
| (APPROVED BY AMA (  |                                  |                        | _                                     | ) Pl                            | LEASE PRINT OR T  | YPE APPROVE                                       | D OMB-0938-0008 FO<br>D OMB-1215-0055 FO | RM CMS               | -1500 (12-     | 90) F   | оям в      | RB-1500                |
|   |                                  |                        |                                       |                                 |   |   |  | 3,70                 |                | - rri   |            |                        |

| PLEASE<br>DO NOT   |                            |                 |               |               |   |                   |   | OHC/RHC                                       | Scr        | ·eer    | ni na          |         |            |             |                              |
|--|----------------------------|-----------------|---------------|---------------|---|-------------------|---|---|------------|---------|----------------|---------|------------|-------------|------------------------------|
| STAPLE IN THIS   |                            |                 |               |               |   |                   |   | eferral                                       |            |         |                |         |            |             |                              |
| AREA   |                            |                 |               |               |   |                   |   | munizat                                       |            |         |                |         |            |             |                              |
| PICA   | 5 64                       | AMPUS           |               | CHAMPVA       | GROUP   |                   | HEALTH INS  | SURANCE<br>1 1a. INSURED'S                    |            |         |                |         | (EOB 6     | BOOD        | PICA TAM IN ITEM 1           |
| MEDICARE MEDICAL     (Medicare #) (Medicaid                          |                            | insor's S       | SSN)          | (VA File      | HEALTH  | D) B              | SLK LUNG (ID)                                     | 1   | 111        |         |                |         | (FOR F     | noun        | NA IN LICINI                 |
| 2. PATIENT'S NAME (Last Name   |                            | Middle          | Initial)      |               | 3. PATIENT'S BIR  | TH DATE           | SEX   | 4. INSURED'S I                                | IAME (I    | Last Na | me, Firs       | t Name, | Middle     | e Initial)  |                              |
| Recipient, Jo<br>5. PATIENT'S ADDRESS (No., S                        | oe<br>itreet)              |                 |               |               | 10 15<br>6. PATIENT REL   | <u> 2002'</u>     |   | 7. INSURED'S                                  | DDRE:      | SS (No  | ., Street)     | ,       |            |             |                              |
| 111 Recipien   |                            | et              |               |               |   | ıse Ch            | oild Other  |   |            |         |                |         |            |             | T                            |
| Recipient To   | w.                         |                 |               | NC            | 8. PATIENT STA  | TUS<br>Married    | Other   | CITY  |            |         |                |         |            |             | STATE                        |
| ZIP CODE   | TELEPHON                   |                 |               | Code)         | Employed  | Full-Time         |   | ZIP CODE                                      |            |         | TEL            | EPHON   | E (INC     | LUDE A      | REA CODE)                    |
| 12345<br>9. OTHER INSURED'S NAME (L                                  | (999)<br>ast Name, Firs    |                 |               |               |   | Student           | Student<br>ON RELATED TO:                         | 11. INSURED'S                                 | POLIC      | Y GRO   | UP OR F        | ECA N   | )<br>UMBEF | a           |                              |
|  |                            |                 |               |               |   |                   | NT OR RESIDENCE                                   |   |            |         |                |         |            |             |                              |
| a. OTHER INSURED'S POLICY  | UH GROUP N                 | UMBER           | 1             |               |   | YES               | NT OR PREVIOUS)                                   | a. INSURED'S I                                | DD         | YY      | н              | м       |            | SEX         | F                            |
| b. OTHER INSURED'S DATE OF   |                            | SE              |               |               | b. AUTO ACCIDE  |                   | PLACE (State)                                     | b. EMPLOYER                                   | NAME       | OR S    | CHOOL          | NAME    |            |             | Name of the last             |
| c. EMPLOYER'S NAME OR SCH  | OOL NAME                   | 1               | F             | 1             | c. OTHER ACCID  | ,                 | Lino L  | c. INSURANCE                                  | PLAN N     | NAME (  | OR PRO         | GRAM M  | NAME       |             | -                            |
|  |                            |                 |               |               | 10d. RESERVED   | YES               | NO  | d. IS THERE AN                                | OTUE       | 211541  | TII DC1        | CELT D  | 4110       |             |                              |
| d. INSURANCE PLAN NAME OF  | PROGRAMI                   | NAME            |               |               | 100. HESERVED   | FUH LUCA          | L USE   | YES   |            |         |                |         |            | complete    | item 9 a-d.                  |
| 12. PATIENT'S OR AUTHORIZE<br>to process this claim. I also re       | D PERSON'S                 | SIGNA           | TURE I        | authorize the | G & SIGNING THIS<br>release of any med<br>r to myself or to the | cal or other i    | information necessary<br>cepts assignment         | 13. INSURED'S<br>payment of r<br>services des | nedical    | benefit |                |         |            |             | authorize<br>or supplier for |
| below.   |                            |                 |               |               |   |                   |   |   |            |         |                |         |            |             |                              |
| SIGNED   | LNESS (First               | sympto          | m) OR         | 15.           | IF PATIENT HAS H  | AD SAME C         | OR SIMILAR ILLNESS.                               | SIGNED<br>16. DATES PAT                       | IENT U     | NABLE   | TO WO          | RK IN C | URRE       | NT OCC      | UPATION                      |
| MM DD YY   | JURY (Accide<br>REGNANCY(I | ent) OR<br>_MP) |               |               | GIVE FIRST DATE   |                   | 31 2003   | 16. DATES PAT<br>MM<br>FROM                   |            |         |                |         |            |             |                              |
| 17. NAME OF REFERRING PHY  | SICIAN OR C                | THERS           | SOURCE        | 176           | I. I.D. NUMBER OF   | REFERNING         | G PHYSICIAN                                       | 18. HOSPITALIZ<br>MM<br>FROM                  | . DD       | YY      | SHELA          | TO      | MM         | DD          | YY                           |
| 19. RESERVED FOR LOCAL US  | SE .                       |                 |               |               | 1000  |                   |   | 20. OUTSIDE LA                                |            |         |                | \$ CHA  | RGES       | 1           |                              |
| 21. DIAGNOSIS OR NATURE OF   | F ILLNESS OF               | NJUF            | Y. (REL       | ATE ITEMS     | 1,2,3 OR 4 TO ITE   | A 24E BY LII      | NE)   | 22. MEDICAID F                                | ESUB       | MISSIO  | IN OBIC        | SINAL R | EE N/C     |             | -181-2                       |
| 1 <u>V20.</u> 2  |                            |                 |               | :             | 3   |                   | *   | 23. PRIOR AUT                                 |            |         |                |         |            |             |                              |
| ² L_ <b>460</b>  |                            |                 |               |               | 4   |                   |   |   | 101112     |         |                | ,       |            |             |                              |
| 24 A DATE(S) OF SERVICE  | Ε,                         | B<br>Place      | C             | PROCEDU       | D<br>RES. SERVICES. C   | R SUPPLIE         | E<br>S DIAGNOSIS                                  | F   |            | DAYS    | EPSDT          |         | J          | RES         | K<br>ERVED FOR               |
| MM DD YY MM  | DD YY                      |                 | of<br>Service |               | ain Unusual Circums CS   MODIFIE                                | A (Ances)         | CODE  | \$ CHARGE                                     |            |         | Family<br>Plan | EMG     | сов        | L           | OCAL USE                     |
| 10 30 03 10  | 30 03                      | 11              | -             | 9939          | 92 EP   |                   | -   |   | 33         | 1       | R              |         |            | +           |                              |
| 10 30 03 10  | 30 03                      | 11              |               | 9047          | 71   EP   |                   |   | 13  | 71         | 1       | _              |         |            | _           |                              |
| 10 30 03 10  | 30-03                      | 11              |               | 9047          | 72   EP   |                   |   | 13  | 71         | 1       |                |         |            |             |                              |
| 10 30 03 10  | 30 03                      | 11              |               | 9064          | 15  |                   |   | 0   | <b>0</b> 0 | 1       |                |         |            |             |                              |
| 10 30 03 10  | 30 03                      | 11              |               | 9066          | 59  |                   |   | 0   | 00         | 1       |                |         |            |             |                              |
|  | į                          |                 |               |               | 1 1   |                   |   |   |            |         |                |         |            |             |                              |
| TS. FEDERAL TAX I.D. NUMBER  | SSN                        | EIN             | 26.1          | PATIENT'S     | ACCOUNT NO.   | 27 ACCI<br>(For g | EPT ASSIGNMENT?<br>ovt. claims, see back)<br>S NO | 28. TOTAL CHA                                 |            |         | 9. AMO         | UNT PA  | ID         | 1           | 107 7                        |
| 31. SIGNATURE OF PHYSICIAN INCLUDING DEGREES OR (                    | CREDENTIAL                 | S               |               |               | ADDRESS OF FAC<br>(If other than home                           |                   | RE SERVICES WERE                                  | 33. PHYSICIAN<br>& PHONE #                    | S, SUP     | PLIER:  |                |         |            |             | ZIP CODE                     |
| (I certify that the statements of<br>apply to this bill and are made |                            |                 |               |               |   |                   |   |   |            |         | ane<br>rov:    |         |            | iei<br>tree | et                           |
| Signature on   | File                       | 11/             | 06/0          | )3            |   |                   |   | PIN# 0000                                     | Pro        |         | der            |         | m,         |             | 12345                        |
| SIGNED SIGNED  |                            |                 |               |               |   |                   |   | D OMB-0938-000                                |            |         |                |         |            |             |                              |

| Recipient Town INC Single Married Other ZIP CODE TELEPHONE (Include Area Code) 12345 (999) 999–9999 9-OTHER INSURED'S NAME (Last Name, First Name, Middle Intitial) 10 IS PATIENT'S CONDITION RELATED TO 11 INSURED'S POLICY OR GROUP NUMBER  a OTHER INSURED'S POLICY OR GROUP NUMBER  a EMPLOYMENT? (CURRENT OR PREVIOUS)  a INSURED'S DATE OF BIRTH  SEX   | PLEASE<br>DO NOT<br>STAPLE<br>IN THIS<br>AREA                        |                        |                                  |                             |  | 0          | FQHC/RHC<br>Interperio  | dic Scr             | reening          | ī                                    |
|---|--|------------------------|----------------------------------|-----------------------------|--|------------|---|---------------------|------------------|--------------------------------------|
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| 111 Recipient Street    City  | 5. PATIENT'S ADDRESS   | (No., Street)          |                                  |                             | 06 11 198  | M X F      |   |                     |                  |                                      |
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| The provider street provider Town, NC 1234  |  | RVICE                  | <del></del>                      |                             | D CES SERVICES OR SURPLUS  |            | F   |                     |                  | К                                    |
| 5. FEDERAL TAX I.D. NUMBER SSN. EIN 26 PATIENTS ACCOUNT NO 27 ACCEPT ASSIGNMENT?  (For ignor, Cairing, see back)  (For ignor,   | MM DD YY MN  | A DD Y                 | of of<br>Service Serv            | l (Explai                   | n Hausual Circumetancock   |            | \$ CHARGES  | OR Family           | EMG COB          | RESERVED F                           |
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| Signature of Physician or supplies   32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE   33 Physicians, supplier   30 BALANCE D   \$ 80   \$3   \$ 80 |  |                        |                                  | 1                           | 1  | 1          |   |                     |                  |                                      |
| Signature of Physician or supplies   32 Name and address of Facility where services were   111 Provider Street  |  |                        |                                  |                             |  |            |   |                     |                  |                                      |
| Signature of Physician or supplies   32 Name and address of Facility where services were   33 Physicians, suppliers billing name, address, 2 80   33   8   80   80   80   80   80   |  |                        |                                  |                             |  |            |   |                     |                  |                                      |
| Signature of Physician or supplies   32 Name and address of Facility where services were   33 Physicians, suppliers billing name, address, 2 80   33   8   80   80   80   80   80   |  |                        |                                  | <del> </del>                |  |            |   |                     |                  |                                      |
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| (APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE APPROVED OMB-0938-0008 FORM CMS-1500 (12-90) FORM RBR-1500   | I. SIGNATURE OF PHYSICI  | R CREDENTIALS          | :                                | NAME AND AD<br>RENDERED (II | PRESS OF FACILITY WHERE  | NO         | 33 PHYSICIAN'S, SUPP<br>& PHONE # Dr.   | Jane<br>Provi       | Provid<br>der St | s 80<br>RESS, ZIP CODE<br>er<br>reet |

| MEAN   MECCAD   CHAMPS   COMPAN   GROUP   Fig.      | PLEASE<br>DO NOT<br>STAPLE<br>IN THIS<br>AREA               |                          |                     |                           |  |                           | °FQHC/F<br>°Period<br>°Visior | lic                  | Scre<br>d he | eni<br>eari | .ng<br>.ng |                     |
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| MINISTER   MORGENE   MOR   |   |                          |                     |                           |  | HEALTH !                  |                               |                      |              |             | _          | PICA                |
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| 3 PATENTS AUDRESS No. Sinete:   111 Recipient Street   | 2 PATIENT'S NAME (Last N                                    | ame. First Na            | me. Middle          |                           |  |                           | 4. INSURED'S NAM              |                      |              | rst Nam     | ie. Midd   | die Initiar)        |
| STATE   PATIENT STATUS   PATIENT STATU   | 5. PATIENT'S ADDRESS (No                                    | . Street)                | reet                |                           | 6. PATIENT RELATIONSHIP  | TO INSURED                | 7 INSURED'S ADD               | RESS                 | io . Stree   | ıt:         |            |                     |
| 20   10   15   15   15   16   16   16   16   16  |   |                          |                     | STA                       | 1.00   | mic Other                 | CITY                          |                      |              |             |            | STAT                |
| 13.345   (999) 999.9999   Employed Fall-time Part Time   Fall Ti   |   |                          | HONE (Incl          |                           | C Single Marned  | Other                     | 710 0005                      |                      |              |             |            |                     |
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| SIGNED   DATE   DATE OF CURRENT   DATE OF CURRENT   DATE   DATE OF CURRENT   DATE   DATE OF CURRENT   DATE   DATE OF CURRENT   DATE   | 12 PATIENTS OF AUTHORIZ                                     | ED PERSO!                | I'S SIGNAT          | TURE Lauthorize           | the release of any medical or other in                                       | nformation necessary      | 13. INSURED'S OR A            | UTHOR                | ZED PE       | RSON'S      | SIGN       | ATURE Lauthour      |
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| TREGNANCY (LIMP)   To MM   |   |                          |                     |                           |  |                           | SIGNED                        |                      |              |             |            |                     |
| 17 NAME OF HEFERRING PHYSICIAN OR OTHER SOURCE   176   10 NUMBER OF REFERRING PHYSICIAN   18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES   18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES   18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES   19 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES   10 OUTSIDE LAB?   20 OUTSIDE LAB?   3 CHARGES   20 MIGHAN      |   | NJURY (Acc<br>PREGNANC   | ident) OR<br>Y(LMP) | l                         | 5. IF PATIENT HAS HAD SAME O<br>GIVE FIRST DATE MM DI                        | R SIMILAR ILLNESS<br>D YY | 16. DATES PATIENT<br>MM DO    | UNABLE               | TO WO        | RK IN C     | URREI      | NT OCCUPATION       |
| 19 RESERVED FOR LOCAL USE   20 OUTSIDE LAB?   S CHARGES  | 17. NAME OF REFERRING PH                                    | YSICIAN OF               | OTHER S             | OURCE 1                   | 7a. I.D. NUMBER OF REFERRING   | PHYSICIAN                 | 18. HOSPITALIZATIO            | N DATE               | S RELAT      | ED TO       | CURRE      | ENT SERVICES        |
| V20.2   2  | 19. RESERVED FOR LOCAL L                                    | SE                       |                     |                           |  |                           |                               |                      |              |             |            | . 55   11           |
| V20.2   3  | 21. DIAGNOSIS OR NATIONS                                    | E II I NECO              | DR IN HUR.          | (DELATE ITE:              | 611100170  |                           | YES                           |                      |              |             |            |                     |
| 21. A   B   C   PROCEDURES, SERVICES OR SUPPLIES   DIAGNOSIS   S   CHARGES   DAYS   EPSDIT   EMG   COB   COPTHOPOS   CODE   CODE   S   CHARGES   CODE   COD  |   |                          | HUUHY               | . (HELATE HEM             |  | =)                        | 22. MEDICAID RESUE<br>CODE    | MISSIC<br>I          | ORIG         | INAL RE     | EF. NO     |                     |
| Property    | 2.1   |                          |                     |                           | s. L   |                           | 23. PRIOR AUTHORIZ            | ATION                | NUMBER       |             |            |                     |
| No.    |   |                          |                     |                           |  | E                         | F                             | G                    |              | 1           | J          | к                   |
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| 11 14 03 11 14 03 11 92552 EP 0 0 00 1  SFEDERAL TAX LD. NUMBER SSN. EIN 26 PATIENTS ACCOUNT NO 27 ACCEPT ASSIGNMENT?  (FOT good Claims, see back) VES NO 80 33 2  SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (It certify that has tatements on the reverse apply to this bill and are made a part thereof)  32. NAME AND ADDRESS OF FACILITY WE NO 33 3PHYSICIANS, SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE A PHONE P. Dr. Joe Provider  111 Provider Street  Provider Town, NC 1234  PINE 00000000 GRP# 10000000C  | 11 14 03 11   | 14 03                    | 11                  | 99                        | 173   EP   |                           | 0.00                          | 1                    |              |             |            |                     |
| S FEDERAL TAX I.D. NUMBER SSN. EIN 26 PATIENTS ACCOUNT NO 27 ACCEPT ASSIGNMENT?  (FOI good Claims, see back) YES NO 8 80 33 29 AMOUNT PAID 30 BALANCE E 8 80  SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (Lentily that the statements on the reverse apply to this bill and are made a part thereof.)  SIGNATURE OF PHYSICIAN OR SUPPLIER SILLING NAME, ADDRESS OF FACILITY WHERE SERVICES WERE 337 PHYSICIANS, SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE 4 PHONE 9 DT. JOE PTOVIDER 111 Provider Street  Provider Town, NC 1234 PIN* 00000000 GRP* 10000000C   |   |                          |                     |                           |  |                           | - 00                          | <u> </u>             | $\dashv$     | -           |            |                     |
| 1 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify this bill and are made a part thereof)  32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE apply to this bill and are made a part thereof)  33 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE apply to this bill and are made a part thereof)  34 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE apply to this bill and are made a part thereof)  35 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE apply to this bill and are made a part thereof)  36 TOTAL CHARGE so TOTAL CHARGE s | 11 14 03 11   | 14_03                    | 11                  | 925                       | 552 EP   |                           | 0 00                          | 1                    |              | _           |            |                     |
| Signature of Physician on Supplier   Signature of Physician on the reverse   Signature on File   Date   11/17/03   Signature on File   Date   11/17/03   Signature on Supplier   Signature on File   Date      |   |                          |                     |                           |  |                           |                               |                      |              |             |            |                     |
| Signature of Physician on Supplier   Signature of Physician on the reverse   Signature on File   Date   11/17/03   Signature on File   Date   11/17/03   Signature on Supplier   Signature on File   Date      |   |                          |                     |                           |  |                           |                               |                      |              | $\top$      |            |                     |
| SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREEDINALS (I certly mat the statements on the reverse apply to this bill and are made a part thereof)  32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE (I certly mat the statements on the reverse apply to this bill and are made a part thereof)  33. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE (A PHONE * Dr. Joe Provider 111 Provider Street Provider Town, NC 1234 PINN 00000000 GRP# 10000000C   |   |                          |                     |                           |  |                           |                               | $\dashv$             |              |             | -+         |                     |
| SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (Lend) that the statements on the reverse apply to this bill and are made a part thereof.)  32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)  33. PHYSICIANS, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE* DT. Joe Provider 111 Provider Street  Provider Town, NC 1234   | FEDERAL TAX I.D. NUMBER                                     | SSN                      | EIN                 | 26 PATIENT'S              | ACCOUNT NO 27 ACCEPT   | F ASSIGNMENT?             | 28 TOTAL CHARGE               | 190                  | AMOUS        | IT DAID     |            | 20 BALANCE T        |
| INCLUDING DEGREES OR CREDENTIALS (If other than home or office)  RENDERED (if other than home or office)  RENDERED (if other than home or office)  PHONE DT. Joe Provider  111 Provider Street  Provider Town, NC 1234  PIN* 0000000 GRP* 1000000C   | SIGNATURE OF PHYSICIAN                                      | OR SUPPLIE               | B                   | 32 NAME AND               | YES  | NO                        | s 80 33                       | 3   5                |              |             |            | s 80 .3             |
| Signature on File DATE 11/17/03 PNN 0000000 GRP 1000000C   | INCLUDING DEGREES OR C<br>(I certify that the statements or | REDENTIAL<br>the reverse | 3                   | RENDERED                  | (If other than home or office)   | SEHVICES WERE             |                               |                      |              |             |            |                     |
| GRE 11/17/03 PINS 0000000 GRP 100000C  |   |                          | (1)                 |                           |  |                           | 111                           | Pr                   | ovid         | ler         | Str        | reet                |
| PINE 000000 GRP# 100000C   | ~•  | File                     | 11/1                | 7/03                      |  |                           |                               | vid                  |              |             |            |                     |
| (APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE  APPROVED OMB-0936-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500. APPROVED OMB-0720-0001 (   | Signature on  |                          |                     | <u>., </u>                |  |                           | PIN# UUUUUU() -               |                      | GA           | P# 10       | υυι        | JUC.                |

| DO NOT<br>STAPLE<br>IN THIS<br>AREA   |               |                      |                                       |  | °FY<br>°II                               | QHC/RHC<br>mmunization  | ns on          | ly           |             |                     |
|---|---------------|----------------------|---------------------------------------|--|--|---|----------------|--------------|-------------|---------------------|
| PICA  |               |                      |                                       |  | HEALTH I                                 | NSURANCE  | CLAIN          | FOR          | М           | Þ                   |
| 1 MEDICARE M (Medicare #) (A  |               | CHAMPU:<br>Sponsor s |                                       | /A GROUP<br>HEALTH PLAN<br># /SSN or ID!                   | FECA OTI<br>BLK LUNG<br>(SSN) (ID        | 12 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1                                  | NUMBER<br>111X |              | (FO         | R PROGRAM II        |
| 2 PATIENT'S NAME (La<br>Recipient   |               | me, Midale           | Initial)                              | 3 PATIENT'S BIRTH DATE                                     | SEX                                      | 4 INSURED'S NAM   | E iLast Nai    | me. First N  | iame, Mic   | ocie initiali       |
| 5. PATIENT'S ADDRESS  | (No., Street) |                      | · · · · · · · · · · · · · · · · · · · | 6 PATIENT RELATIONSHI                                      |  | 7 INSURED'S ADD   | RESS (NO.      | Street       |             |                     |
| 111 Recip   | tent St.      | reer                 | STATE                                 | Self Spouse C  | hild Other                               | CITY  |                |              |             | Ts1                 |
| Recipient   |               | IONE (incl           | NC                                    | Single Married   | Other                                    | ZIP CODE  |                | T            |             |                     |
| 12345   | ( 99          | 99 99                | 9-9999                                | Employed Full-Time<br>Student                              | Student                                  |   |                | (            | )           | NCLUDE AREA         |
| 9. OTHER INSURED'S N  |               |                      |                                       | 10 IS PATIENT'S CONDITI                                    | ON RELATED TO                            | 11. INSURED'S POL   | ICY GROU       | P OR FEC     | A NUMB      | ER                  |
| a. OTHER INSURED'S PO   | DLICY OR GROU | NUMBER               | 7                                     | a EMPLOYMENT? (CURRE                                       | NT OR PREVIOUS)                          | a INSURED'S DATE  | OF BIRTH       |              | м .         | SEX                 |
| b. OTHER INSURED'S DA<br>MM DD YY   |               | SE:                  | х                                     | b. AUTO ACCIDENT?  | PLACE (State                             | b. EMPLOYER'S NA  | MÉ OR SCI      | HOOL NA      |             |                     |
| c. EMPLOYER'S NAME O  |               |                      |                                       | C OTHER ACCIDENT?  | NO                                       | c. INSURANCE PLAI   | N NAME OF      | PROGRA       | AM NAME     |                     |
| d. INSURANCE PLAN NA  | ME OR PROGRA  | M NAME               |                                       | YES 100 RESERVED FOR LOCA                                  | NO<br>USE                                | d IS THERE ANOTH  | ED HEATT       | DENEEL       | T. D        |                     |
|   | 0540 0404 05  |                      |                                       | 3 & SIGNING THIS FORM.                                     |  | 1   | NO NO          | If yes. retu | irn to and  | complete item :     |
| 19 RESERVED FOR LOCA 21 DIAGNOSIS OR NATUR 1  |               |                      | 3                                     | .2.3 OR 4 TO ITEM 24E BY LIN                               | EI                                       | FROM  20 OUTSIDE LAB?  YES  22 MEDICAID RESULT  CODE  23 PRIOR AUTHORIZ | MISSION        | \$ C         | HARGES      | Ц                   |
| DATE(S) OF SE<br>From   |               | of                   | of (Evolu-                            | D<br>ES, SERVICES, OR SUPPLIES<br>n Unusual Circumstances) | DIAGNOSIS<br>CODE                        | \$ CHARGES  |                | SDT          | J           | RESERVED            |
|   | 0 20 03       | Services<br>11       | - 1                                   | 71 EP  | 3302                                     | 13 71   | UNITS F        | lan EM       | S COB       | LOCAL U             |
| 10 20 03 1  | 0 20 03       | 11                   | 904                                   | 72   EP  |  | 13 71   | 1              | +            | $\dagger$   |                     |
|   | 0 20 03       |                      | 907                                   |  |  | 0 00  | 1              |              | +-          | 1                   |
|   | 0 20 03       | 1                    | 9070                                  |  |  |   |                | +-           | +           |                     |
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| 10 20 03 1  | - 20 03       |                      | 9070                                  | 10   |  | 0 00  | 1              |              |             |                     |
| 5 FEDERAL TAX I D. NUMI   | BER SSN       | EIN                  | 26 DATIFAITS 12                       | COUNT NO.  |  |   |                |              |             |                     |
|   |               |                      | 26 PATIENT'S AC                       | (For gov<br>YES  | T ASSIGNMENT?<br>claims, see back)<br>NO | s 27 42   |                | MOUNT P      | AID<br>:    | 30 BALANCE<br>\$ 27 |
| IT SIGNATURE OF PHYSIC<br>INCLUDING DEGREES O<br>(I certify that the statemen<br>apply to this bill and are m | R CREDENTIALS | 3                    | 32. NAME AND AD RENDERED (III         | DRESS OF FACILITY WHERE other than home or office)         | SERVICES WERE                            | 111   | Jane<br>Prov   | Pro<br>ider  | vide<br>Str | RESS, ZIP COD       |

| ## HEALTH INSURANCE CLAIM FORM    MEDICANE   MEDICAD   CHAMPINS   CHAMPINS   CHAMPINS   PROCESSION   PROCESSI  | DO NOT<br>STAPLE<br>IN THIS  |                                |                           |               |                            | °C             | QHC/RHC<br>Core Visit                                |          |           |           |              |                 |
|---|--|--------------------------------|---------------------------|---------------|----------------------------|----------------|--|----------|-----------|-----------|--------------|-----------------|
| Michael   Mich  | AREA   |                                |                           |               |                            | °I             | mmunizati  | ons      |           |           |              |                 |
| Medicate   1  |  | AID CHA                        | MPUS                      | CHAMPVA       | GROUP                      | EECA OTH       |  |          |           | ORI       |              | P               |
| Recipient Street  | I  |                                |                           | (VA File      |                            | (SSN) - (ID)   | 22222  | 2222     | 2X        |           |              |                 |
| 111   Recipient Street  | Recipient,   | oe                             | widdle iriitial)          |               | 1 <sup>8</sup> 2 05 2001   | M -X 3EX F     | 4 INSURED'S NA                                       | ME (Las  | t Name.   | First Na  | me. Mia      | dle Initial)    |
| STATE   PATENTS TATUS   PATENT STATUS   PATENT STATUS   Single   Married   Other   O  | 111 Recipier   | Street)<br>It Stree            | et                        |               |                            |                | 7 INSURED'S AD                                       | DRESS    | No . Str  | eet)      |              |                 |
| 12345   | 1  | V-770                          |                           |               |                            |                | CITY   |          |           |           |              | ST              |
| 12345   1999 999 999   10   10   15   15   15   15   15   15  |  |                                | (include Area (           |               |                            |                | ZIP CODE   |          | Т         | ELEPH     | ONE (IN      | ICLUDE AREA     |
| a OTHER INSUREDS POLICY OR GROUP NUMBER  a EMPLOYMENT (CURRENT OR PREVIOUS)  VES NO  D. OTHER INSUREDS DATE OF BIRTH  SEX  MM DD YV  M  C EMPLOYER'S NAME OR SCHOOL NAME  c OTHER ACCIDENT?  VES NO  C INSURANCE PLAN NAME OR PROGRAM NAME  d INSURANCE PLAN NAME OR PROGRAM NAME  100 RESERVED FOR LOCAL USE  12 PATIENTS OR AUTHORIZED PERSON'S SIGNATURE: I authorise the revision of the public who accepts assignment to process the claim I also request payment of genement benefits either in proget of the public who accepts assignment to process the claim I also request payment of genement benefits either in proget in the public who accepts assignment to process the claim I also request payment of reversible size in a programment personal payment of presented benefits either in proget or to the public who accepts assignment to process the claim I also request payment of genement benefits either in proget or to the public who accepts assignment to process the process to the undersible of the undersible of the public process assignment to process the programment benefits either in programment personal payment of received benefits to be undersible to the undersible of the public payment of received benefits to be undersible to the undersible of the programment payment of received benefits to be undersible to the undersible of the programment payment of received benefits to be undersible to the undersible of the programment payment of received benefits to be undersible to the undersible of the programment payment of received benefits to be undersible to the undersible of the programment payment of received benefits to be undersible to the undersible of the programment payment of received benefits to be undersible to the undersible of the programment payment of received benefits to the undersible of the programment payment of received benefits to the undersible of the programment payment of received benefits to the undersible of the programment payment of received benefits to the undersible of the programment payment of receiv  | 12345<br>9. OTHER INSURED'S NAME   | (999)<br>Last Name, First      | 999-99<br>Name, Middle is | 99<br>nitiali | Student                    | Student        | 11 INSTIBET'S DO                                     | niev ė   |           | (         | )            |                 |
| SOME DESCRIPTION   SEX   SO   AUTO ACCIDENT?   PLACE ISSUE   SEMPLOYER'S NAME OR SCHOOL NAME   SEX   VES   NO   VES   NO   C. INSURANCE PLAN NAME OR SCHOOL NAME   C. OTHER ACCIDENT?   PLACE ISSUE   SEMPLOYER'S NAME OR SCHOOL NAME   C. OTHER ACCIDENT?   VES   NO   | a OTHER INSURED'S POLICE   | OB GBOUR PILE                  | MRED                      |               |                            |                |  |          |           | n FECA    | NUMB         | ER              |
| D. OTHER ASUREDS DATE OF BIRTH   SEX  |  |                                | mdEH                      |               |                            |                | a INSURED'S DAT                                      | E OF BU  | RTH<br>YY |           | м —          | SEX             |
| C. IMPLOYER'S NAME OR SCHOOL NAME   | b. OTHER INSURED'S DATE (  |                                |                           |               |                            | _              | b EMPLOYER'S N                                       | AME OR   | SCHOO     | L NAM     | E            |                 |
| 10 RESERVED FOR LOCAL USE   | c. EMPLOYER'S NAME OR SO   |                                |                           |               | OTHER ACCIDENT?            |                | c. INSURANCE PLA                                     | AN NAM   | OR PR     | OGRAN     | d NAME       |                 |
| 2 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE:   authorize the release of any medical or other information necessary to proceed a some also request payment of government benefits either to myself of to the party who accepts assignment   3 INSURED SIGNATURE:   authorize the release of any medical or other information necessary to proceed a some also request payment of government benefits either to myself of to the party who accepts assignment   3 INSURED SIGNATURE:   authorize the release of any medical or other information necessary to proceed a some and also request specified below.   3 INSURED SIGNATURE:   authorize the release of any medical or other information necessary to proceed a some all also requests persons signature in a some and also requests persons in a some and also requests persons signature in a some and also request persons signature in a some and also requests persons signature in a superson of the interest of the party who accepts assignment   Signature of medical benefits to the understance signature in and and also requests persons in a superson of the some and also requests persons in a superson of the some and also persons in the some and also requests persons and and also requests persons and also re  | d. INSURANCE PLAN NAME O   | PROGRAM NA                     | ME                        | 1             |                            |                | d. IS THERE ANOTE                                    | HER HE   | ALTH PE   | NEET      | PI AND       |                 |
| ADTE OF CURRENT   | REAL   | BACK OF FOR                    | H BEEODE CO.              | MD) ETING     | Sichura Tura sassi         |                | YES  | . NO     | If ye     | s. returi | n to and     | complete item 9 |
| 382-9   3   | 17. NAME OF REFERRING PHY  19. RESERVED FOR LOCAL US                       | REGNANCYILME<br>SICIAN OR OTHE | en source                 | 17a. I.C      | ). NUMBER OF REFERRING     | PHYSICIAN      | FROM  18. HOSPITALIZATIO FROM  20. OUTSIDE LAB?  YES | DN DATE  | S RELA    | TED TO    | O CURR<br>MM |                 |
| 24 A B C D E F G H J J K RESERVICE TO DIAGNOSIS SCHULCES OR SUPPLIES DIAGNOSIS CODE S CHARGES OR SUPPLIES DIAGNOSIS CODE S CHARGES OR CEPTHACKS IN MODIFIER DIAGNOSIS CODE S CHARGES OR CODE S COD  |  |                                |                           |               |                            | ·' +           |  |          |           |           | REF NO       | ),              |
| Pace   Type   Procedures Services   Procedures   Procedures Services   Procedures   |  |                                |                           | 4. L          |                            |                | 23 PRIOR AUTHORI                                     | ZATION   | NUMBE     | R         |              |                 |
| MM   DO   YY   MM   DO   YY   Service   Service   CPTHCPUS   MODIFIER   CODE   S CHARGES   ON T   Pian   EMG   COB   LOCALU   |  | To Pia                         | ice Type PR               | OCEDURES      | D<br>SERVICES, OR SUPPLIES | E<br>DIAGNOSIS | F  | DAYS     | EPSD1     | 1         | J            |                 |
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| 10 20 03 10 20 03 11 90707 0 00 1 1 10 20 03 11 90645 0 00 1 1 5 FEDERAL TAX IO NUMBER SSN EN 26 PATIENTS ACCOUNT NO 27 ACCEPT ASSIGNMENT? (FOI good: claims, see back) (FOI good: claims, see back) 28 TOTAL CHARGE 29 AMOUNT PAID 30 BALANCE (FOI good: claims, see back) 5 65 00 \$ \$ 65 00 | 10 20 02 10  |                                |                           |               |                            |                |  | +        | -         | _         | -            |                 |
| 10 20 03 10 20 03 11 90645 0 00 1   90645   |  | -5 05 1                        | -                         | 70700         | <u> </u>                   |                |  | <u> </u> |           |           |              |                 |
| 5 FEDERAL TAX I D NUMBER SSN EIN 26 PATIENT'S ACCOUNT NO 27 ACCEPT ASSIGNMENT? (FOI 90N LEIMS, see Dack) 27 ES NO 5 65 00 S 5 65 00 S 5 65 00 S S 65 00 S S 65 00 S S S S S S S S S S S S S S S S S S   | 10 20 03 10  |                                | 1                         | 90707         | '                          |                | 0 00   | 1        |           |           |              |                 |
| SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part interest).  29 AMOUNT PAID 30 BALANCE  VES NO \$ 65 00 \$ \$ 65  32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)  31 PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODI 8 PHONE * Dr. Jane Provider   | 10 20 03 10  | 20 03 1                        | 1 1                       | 00645         |                            |                | 0 00   | 1        |           |           |              |                 |
| 1 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof to the part of the part  | 10 20 03 10 .<br>10 20 03 10 .   | +                              |                           | 90645         |                            |                |  | _        |           |           |              |                 |
| SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part interest).  29 AMOUNT PAID 30 BALANCE  VES NO \$ 65 00 \$ \$ 65  32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)  31 PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODI 8 PHONE * Dr. Jane Provider   | 10 20 03 10 .<br>10 20 03 10 .   | +                              | 1                         | 90645         |                            |                |  |          | , ,       |           |              |                 |
| SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part tierset)  32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)  33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODI  8. PHONE ** Dr. Jane Provider*  Tor. Jane Provider*   | 10 20 03 10 .<br>10 20 03 10 .   | +                              | 1                         | 90645         |                            |                |  | -        |           |           |              |                 |
| Signature on File 111 Provider Street Provider Town,NC 12345  GREE PRINTO000000 GREE 100000A  | 10 20 03 10 10 10 20 03 10 10 20 03 10 10 10 10 10 10 10 10 10 10 10 10 10 | 20 03 11                       |                           |               |                            | ASSIGNMENT?    | 28 TOTAL CHARGE                                      | 2:       | 9. AMOL   | INT PAI   | D            | 30. BALANCE [   |

# SCREEN ENTRY EXAMPLES OF THE SERVICES SCREEN (OPTION 65) FOR <u>LOCAL HEALTH DEPARTMENTS</u> THAT USE THE N.C. HEALTH SERVICES INFORMATION SYSTEM (HSIS)

Example #1 – Health Check Periodic Screening for a 1-month-old Child Receiving Two Immunizations.

| NEXT RECORD: COUNT<br>MESSAGE:                         | TY 999 SCREE  | N 65 ID | 22222222   | DATE 12    | 1002 ACTIO  | ON A  |  |  |  |  |  |  |
|--|---------------|---------|------------|------------|-------------|-------|--|--|--|--|--|--|
| NAME: Brown, Charlie DATE OF DIAB EVAL: SERVICE GROUP: |               |         |            |            |             |       |  |  |  |  |  |  |
| DIAG CODES A: V20.2                                    | 2 B: C:_      | D:_     | E: _       | F: _       | G:          |       |  |  |  |  |  |  |
| н:   | <del></del>   |         | $^{ m HL}$ | TH CHK/EDS | DT REFERRAL | : _   |  |  |  |  |  |  |
| PHY ORDER DATE FOR                                     | R AT:         | OT:     | PT:        | _ SPL:     |             |       |  |  |  |  |  |  |
| B/   |               |         |            |            |             |       |  |  |  |  |  |  |
| R/ MODI  | IFIERS DIAG   | SVC     |            | ATN TYP    | REF POST    |       |  |  |  |  |  |  |
| D PGM CPT M1 N   | M2 M3 1 2 3 4 | PROV U  | NITS POS   | PHY SVC    | PHY OP      | SITE  |  |  |  |  |  |  |
| B CH 99381 EP _  | A             | ROS     | 01 71 _    |            |             | 99999 |  |  |  |  |  |  |
| R CH 90744   | A             | ROS     | 01 71 _    |            |             | 99999 |  |  |  |  |  |  |
| R CH 90700   | A             | ROS     | 01 71 _    |            |             | 99999 |  |  |  |  |  |  |

Example #2 – Health Check Periodic Screening for an 18-Year-Old with an Additional Procedure, Plus Vision and Hearing Screenings. Diagnosis warrants a referral for a follow-up visit, designated with "R" entered in the HLTH CHK/EPSDT REFERRAL data field.

| l   | rec<br>SAGE:  | CORD:             | COUN | TY.  | 999  |     | SC  | REEN | 65   | ID   | 333   | 3333 | 33 ] | DATE | 12090 | 2 AC   | TION A |
|-----|---|-------------------|------|------|------|-----|-----|------|------|------|-------|------|------|------|-------|--------|--------|
|     |   | atty, P<br>GROUP: |      | ermi | int  |     |     |      |      |      |       |      | DAT  | E OF | DIAB  | EVAL:_ |        |
|     | DIAG CODES A: V20.2 B: 460. C: D: E: F: G:  H:  PHY ORDER DATE FOR AT: OT: PT: SPL: |                   |      |      |      |     |     |      |      |      |       |      |      |      |       |        |        |
| PH? | Y ORI   | DER DAT           | E FC | OR A | T: _ |     |     | ΓO   | ':   | E    | PT: _ |      | _ SP | ւ։   |       |        |        |
| B/  |   |                   |      |      |      |     |     |      |      |      |       |      |      |      |       |        |        |
| R/  |   |                   | MOI  | )IF] | ERS  | DI. | AG  |      | SVC  |      |       |      | ATN  | TYP  | REF   | POST   |        |
| D   | PGM   | CPT               | M1   | M2   | М3   | 1   | 2 3 | 4    | PROV | UNIT | S P   | OS   | PHY  | SVC  | PHY   | OP     | SITE   |
| В   | CH  | 99385             | EP   |      |      | A   |     | _    | ROS  | _ 01 | 7.    | 1 _  |      |      |       | _      | 99999  |
| В   | CH  | 87081             |      |      |      | В   |     | _    | ROS  | _ 01 | 7.    | 1 _  |      |      |       | _      | 99999  |
| R   | CH  | 99173             |      |      |      | Α   |     | _    | ROS  | _ 01 | 7.    | 1 _  |      |      |       | _      | 99999  |
| R   | CH  | 92551             |      |      |      | A   |     | _    | ROS  | _ 01 | 7.    | 1 _  |      |      |       | _      | 99999  |

#### N.C. Health Services Information System Screen Examples, continued

Example #3 – Health Check Interperiodic Screening for a 4-Year-Old Child Receiving Two Immunizations.

| NEXT RECORD: COUNTY 999 MESSAGE:                      | SCREEN 65  | ID 44444444  | .4 DATE 120902   | ACTION A  |  |  |  |  |  |  |  |  |  |
|---|------------|--------------|------------------|-----------|--|--|--|--|--|--|--|--|--|
| NAME: Smith, Barbie DATE OF DIAB EVAL: SERVICE GROUP: |            |              |                  |           |  |  |  |  |  |  |  |  |  |
| DIAG CODES A: V70.3_ B:_                              | c:         | D: E:        | F:               | G:        |  |  |  |  |  |  |  |  |  |
| н:  |            | Н            | LTH CHK/EDSDT RE | FERRAL: _ |  |  |  |  |  |  |  |  |  |
| PHY ORDER DATE FOR AT:                                | OT:        | PT:          | SPL:             |           |  |  |  |  |  |  |  |  |  |
| B/  |            |              |                  |           |  |  |  |  |  |  |  |  |  |
| R/ MODIFIERS  | DIAG SV    | C            | ATN TYP REF      | POST      |  |  |  |  |  |  |  |  |  |
| D PGM CPT M1 M2 M3                                    | 1 2 3 4 PR | OV UNITS POS | PHY SVC PHY      | OP SITE   |  |  |  |  |  |  |  |  |  |
| B CH 99382 EP   | A RO       | S 01 71 _    |                  | _ 99999   |  |  |  |  |  |  |  |  |  |
| R CH 90645  | A RO       | S 01 71 _    |                  | _ 99999   |  |  |  |  |  |  |  |  |  |
| R CH 90658  | A RO       | S 01 71 _    |                  | _ 99999   |  |  |  |  |  |  |  |  |  |

Example #4 – Health Check Periodic Screening and Immunizations for Child Age 1 with Referral/Follow-up Indicator. Diagnosis warrants a referral for a follow-up visit, designated with "R" entered in the HLTHCHK/EPSDT REFERRAL data field.

|     | T REC |        | COUNTY   | 999    | SCREEN | 65   | ID 444 | 44444 | 4 DATE    | 120902  | ACT:  | ION A |  |
|-----|-------|--------|----------|--------|--------|------|--------|-------|-----------|---------|-------|-------|--|
| MES | SAGE: |        |          |        |        |      |        |       |           |         |       |       |  |
|     |       | •      | Christo  | opher  |        |      |        |       | DATE OF   | DIAB E  | VAL:  |       |  |
| SER | VICE  | GROUP: | :        |        |        |      |        |       |           |         |       |       |  |
| DIA | G COD | DES A: | V20.2_   | B:460  | · C:_  | ·    | D:     | E:    | F         | :       | _ G:_ |       |  |
|     |       | Η:     | ·        |        |        |      |        |       | HLTH CHK/ | EDSDT R | EFERR | AL: R |  |
| PH  | Y ORD | ER DAT | TE FOR A | AT:    | 0'     | T:   | PT     | :     | SPL:      |         |       |       |  |
| B/  |       |        |          |        |        |      |        |       |           |         |       |       |  |
| R/  |       |        | MODIF    | IERS D | IAG    | SVC  |        |       | ATN TY    | P REF   | POST  |       |  |
| D   | PGM   | CPT    | M1 M2    | M3 1   | 2 3 4  | PROV | UNITS  | POS   | PHY SV    | C PHY   | OP    | SITE  |  |
| В   | CH    | 99392  | EP       | A      |        | ROS  | _ 01   | 71    |           |         | _     | 99999 |  |
| R   | CH    | 90645  |          | A      |        | ROS  | _ 01   | 71    |           |         | _     | 99999 |  |
| R   | CH    | 90669  |          | A      |        | ROS  | 01     | 71    |           |         |       | 99999 |  |

## N.C. Health Services Information System Screen Examples, continued

#### Example #5 – Immunization Administration Fee ONLY for Child Age 3.

| NEXT RECORD: COU<br>MESSAGE         | JNTY 999 S   | CREEN 65 | ID 555! | 555555 D | ATE 112202 | 2 ACTION A |
|-------------------------------------|--------------|----------|---------|----------|------------|------------|
| NAME: Barkley, Ch<br>SERVICE GROUP: | narles       |          |         | DATE     | OF DIAB E  | EVAL:      |
| DIAG CODES A: V06                   | 5.8_B:       | C:       | D:      | _ E:     | F:         | _ G:       |
| н:                                  | _•           |          |         | HLTH CHK | /EDSDT REF | TERRAL:    |
| PHY ORDER DATE I                    | FOR AT:      | OT:      | PT      | : SF     | L:         |            |
| B/                                  |              |          |         |          |            |            |
| R/ MC                               | DDIFIERS DIA | .G SVC   | !       | ATN      | TYP REF    | POST       |
| D PGM CPT M1                        | L M2 M3 1 2  | 3 4 PRC  | V UNITS | POS PHY  | SVC PHY    | OP SITE    |
| B IM 90471 E                        | P A          | NUR      | SE 01   | 71       |            | _ 99999    |
| R IM 90700                          | A            | NUR      | SE 01   | 71       |            | 99999      |
| R IM 90713                          | A            | NUR      | SE 01   |          |            |            |
| R IM 90744                          | A            | NUR      | SE 01   | 71       |            | 99999      |
| R IM 90647                          | A            | NUR      | SE 01   | 71       |            | 99999      |

## Example #6 – Office Visit with One Immunization for a Child Age 2.

| NEXT RECORD: COUNTY !  | 999 SCREEN 65 | ID 66666666  | DATE 111402           | ACTION A |  |  |  |  |  |  |  |  |
|--|---------------|--------------|-----------------------|----------|--|--|--|--|--|--|--|--|
| NAME: Smith, Hercules DATE OF DIAB EVAL:  SERVICE GROUP: THRU DT:  DIAG CODES A: 382.9 B: C: D: E: F: G: |               |              |                       |          |  |  |  |  |  |  |  |  |
| DIAG CODES A: 382.9_<br>H: .   | B:            |              | F:<br>TH CHK/EDSDT RE |          |  |  |  |  |  |  |  |  |
| PHY ORDER DATE FOR A   | T: OT:        |              | ·                     | TERRAD.  |  |  |  |  |  |  |  |  |
| B/<br>R/ MODIFI  | ERS DIAG SVC  | AT           | IN TYP REF            | POST     |  |  |  |  |  |  |  |  |
| D PGM CPT M1 M2 I  |               | UNITS POS PH | HY SVC PHY            | OP SITE  |  |  |  |  |  |  |  |  |
| B CH 99212   | A PHY         | 01 71        |                       | _ 99999  |  |  |  |  |  |  |  |  |
| B CH 90471 EP  | A NURS        |              |                       | _ 99999  |  |  |  |  |  |  |  |  |
| R CH 90716   | A NURS        | E 01 71      |                       | _ 99999  |  |  |  |  |  |  |  |  |

# TIPS FOR DECREASING DENIALS

| EOB  | Message   | Tip   |
|------|---|---|
| 010  | Diagnosis or service invalid for recipient age. Verify MID, diagnosis, procedure code or procedure code/modifier combination for errors. Correct and submit as a new claim.       | Verify the recipient's Medicaid identification (MID) number, DOB, diagnosis, and procedure codes.  Make corrections, if necessary, and resubmit to EDS as a new claim. If all information is correct, send the claim and RA to the DMA Claims Analysis Unit, 2519 Mail Service Center, Raleigh, NC 27699-2519.          |
| 060  | Not in accordance with medical policy guidelines.   | Verify that only one vision and/or hearing screening is billed per date of service. Make corrections and resubmit as a new day claim.   |
| 082  | Service is not consistent with/or not covered for this diagnosis/or description does not match diagnosis.   | Verify diagnosis code is V20.2 or V70.3 for the Health Check screening according to the billing guidelines on page 9. Correct claim and resubmit.   |
| 349  | Health Check screening and related service not allowed same day, same provider or member of same group. Resubmit as an adjustment with documentation supporting related services. | Verify if related services billed on same or different claim as the Health Check screening are Health Check components. Health Check screening and related services will not be paid for same date of service initially. Resubmit as an adjustment with medical documentation supporting the need for related services. |
| 685  | Health Check services are for Medicaid recipients birth through age 20 only.  | Verify recipient's age. Only recipients age birth through 20 years of age are eligible for Health Check program services.   |
| 1036 | Thank you for reporting vaccines. This vaccine was provided at no charge through VFC Program. No payment allowed.   | Immunizations(s) are available at no charge through the UCVDP/VFC Program.  |
| 1058 | The only well child exam billable through the Medicaid program is a Health Check screening. For information about billing Health Check, please call 1-800-688-6696.               | Bill periodic screening with V20.2 and interperiodic screenings with V70.3. Check the preventive medicine code entered in block 24D of the claim form.  |
| 1422 | Immunization administration not allowed without the appropriate immunization. Refer to the most recent Health Check special bulletin.   | Check the claim to ensure that the immunization procedure code(s) are billed on the same claim as the immunization administration code(s). Make corrections and resubmit as a new day claim.  |

# Tips For Decreasing Denials, continued

| EOB  | Message  | Tip   |
|------|--|---|
| 1769 | No additional payment made for vision and/or hearing services.   | Payment is included in Health Check reimbursement.  |
| 1770 | Invalid procedure/modifier/diagnosis code combination for Health Check or Family Planning services. Correct and resubmit as a new claim. | Health Check services must be billed with the diagnosis code V20.2 or V70.3 and the EP modifier. Verify the correct diagnosis code, procedure code and modifier for the service rendered. Family planning services must be billed with the FP modifier and the diagnosis code V250.9. |
| 1771 | All components were not rendered for this Health Check screening.  | For periodic screenings, verify all required components, such as vision and or hearing assessments were performed and reported on the claim form using the EP modifier. Make corrections and resubmit as a new day claim.   |

## HEALTH CHECK BILLING WORKSHEET

The Health Check Billing Worksheet (see page 40) may be used in your practice to facilitate Health Check billing.

For additional billing questions please contact EDS at 1-800-688-6696 or 919-851-8888.

# HEALTH CHECK BILLING WORKSHEET

| Patient's Name     | Next Screening Date (optional) |
|--------------------|--------------------------------|
| Medicaid ID number | Date of Birth                  |

| Health Check Diagnosis Code          |  |  |
|--------------------------------------|--|--|
| Periodic Health Check Screening      | Periodic Health Check Screening V20.2      |  |
| Interperiodic Health Check Screening | Interperiodic Health Check Screening V70.3 |  |

| Health Check Screening Code                         |  |                |   |
|---|--|----------------|---|
| Description   | Preventive Medicine Codes  | Diagnosis Code | ✓ |
| Regular Periodic Screening - Birth through 20 years | 99381-9985; 99391-99395<br>With EP Modifier                      | V20.2          |   |
| Vision Assessment based on age                      | Vision Assessment CPT Code<br>99172 or 99173<br>With EP Modifier |                |   |
| Hearing Assessment based on age                     | Hearing Assessment CPT<br>Code 92551or 92552<br>With EP Modifier |                |   |
| Interperiodic Screening - Birth through 20 years    | 99381-9985; 99391-99395<br>With EP Modifier                      | V70.3          |   |

| Second Diagnosis (if applicable)                      |           |          |
|---|-----------|----------|
| Description   | Indicator | <b>✓</b> |
| Follow-up with screening provider or another provider | R         |          |

| Third Diagnosis (if applicable)                       |           |   |
|---|-----------|---|
| Description   | Indicator | ✓ |
| Follow-up with screening provider or another provider | R         |   |

| Fourth Diagnosis (if applicable)                      |           |          |
|---|-----------|----------|
| Description   | Indicator | <b>✓</b> |
| Follow-up with screening provider or another provider | R         |          |

| Description                                | CPT Codes         | Unit             |  |
|--|-------------------|------------------|--|
| Immunization Administration Fee            | 90471 EP Modifier | One immunization |  |
| Additional Immunization Administration Fee | 90472 EP Modifier | Additional       |  |
|  |                   | immunizations    |  |

# IMMUNIZATION BILLING WORKSHEET\*

| Code  | Description  | Diagnosis       | VFC                |
|-------|--|-----------------|--------------------|
| 90281 | Immune Globulin  | V07.2           |                    |
| 90371 | Hepatitis B Immune Globulin                                    | V07.2           |                    |
| 90375 | Rabies Immune Globulin   | V07.2           |                    |
| 90376 | Rabies Immune Globulin – Heat treated (RIG-HT)                 | V07.2           |                    |
| 90384 | Rho (D) Immune Globulin Full Dose                              | V07.2           |                    |
| 90385 | Rho (D) Immune Globulin Mini Dose                              | V07.2           |                    |
| 90389 | Tetanus Immune Globulin  | V07.2           |                    |
| 90396 | Varicella-Zoster Immune Globulin                               | V07.2           |                    |
| 90585 | BCG  | V03.2           |                    |
| 90632 | Hepatitis A Vaccine – Age 18 & up                              | V05.8           |                    |
| 90633 | Hepatitis A Vaccine – 2 dose Age 2 & up                        | V05.8           |                    |
| 90645 | Hib Titer – 4 dose   | V03.8 or V05.8  | VFC 2 mo – 5 yrs   |
| 90647 | Hib – 3 dose (Brand name – PedVax)                             | V03.8 or V05.8  | VFC 2 mo – 5 yrs   |
| 90648 | Hib – 4 dose (Brand name – ActHib)                             | V03.8 or V05.8  | VFC 2 mo – 5 yrs   |
| 90657 | Influenza Split Virus (6-35 months of age)                     | V04.8           | VFC 6 mo – 35 mo   |
| 90658 | Influenza Split Virus (3 years and above)                      | V04.8           | VFC 3 yrs – 18 yrs |
| 90669 | Pneumococcal PCV7 (2-59 months)                                | V03.82 or V05.8 | VFC 2 mo – 59 mo   |
| 90675 | Rabies Vaccine – IM  | V04.5           |                    |
| 90700 | DTaP   | V06.8           | VFC 2 mo – 7 yrs   |
| 90702 | DT – Age under 9   | V06.8           | VFC 2 mo – 6 yrs   |
| 90703 | Tetanus Toxoid   | V03.7           |                    |
| 90704 | Mumps  | V04.6           |                    |
| 90705 | Measles  | V04.2           |                    |
| 90706 | Rubella  | V04.3           |                    |
| 90707 | MMR  | V06.4           | VFC 12 mo – 18 yrs |
| 90713 | IPV (Injectable Polio Vaccine)                                 | V04.0           | VFC 2 mo – 18 yrs  |
| 90716 | Varicella  | V05.4           | VFC 12 mo – 18 yrs |
| 90718 | Td   | V06.5           | VFC 7 yrs – 18 yrs |
| 90721 | DTaP/Hib   | V06.8           |                    |
| 90732 | Pneumococcal PPV23 (High Risk Only)                            | V03.82 or V05.8 | VFC 2 yrs – 18 yrs |
| 90733 | Meningococcal  | V03.89          |                    |
| 90744 | Hepatitis B Vaccine – Pediatric/adol -3 dose                   | V05.8           | VFC 0 – 18 yrs     |
| 90746 | Hepatitis B Vaccine – Age 19 and above                         | V05.8           |                    |
| 90747 | Hepatitis B Vaccine - Dialysis<br>Pt./immunosuppressed -4 dose | 585             |                    |

Note: This list is subject to change.

Nina M. Yeager, Director

Division of Medical Assistance Department of Health and Human Services Executive Director EDS

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